TEXAS REGISTER

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Artist: *Daniel Price*

10th Grade

DeSoto High School, DeSoto ISD

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Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(800) 226-7199
(512) 463-5561
FAX (512) 463-5569

Secretary of State - Antonio O. Garza, Jr.

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Receptionist - Cam Sorrell

Texas Administrative Code
Dana Blanton
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TABLES AND GRAPHICS

OPEN MEETINGS

IN ADDITION

ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code, Title 4, §402.042 and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open record decisions are summarized for publication in the ***Texas Register***. The Attorney General responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the Attorney General unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. To request copies of opinions, phone (512) 462-0011. To inquire about pending requests for opinions, phone (512) 463-2110.

Open Records Request

ORQ-21(ID# 104307). Request from Sonya Letson, County Attorney, Potter County, 500 South Fillmore, Room 303, Amarillo, Texas 79101, concerning whether a public employee commits an offense under §552.351 of the Government Code by consciously updating computer records, and related questions.

TRD-9701580

Opinions

DM-422(RQ-856). Request from Don Gilbert, Commissioner, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668 concerning applicability of Senate Bill 646, Act of May 27, 1995, 74th Legislature, Regular Session, Chapter 854, 1995 Texas General Laws 4287, 4288, which relates to veterans' employment preference.

Summary The preference for veterans in a reduction workforce mandated by §657.007 of the Government Code is not absolute. Veterans are to be preferred when selection among similarly qualified and similarly situated employees, but are not entitled preference over more qualified employees who are not veterans.

DM-424(RQ-903). Request from Dr. Mike Moses, Commissioner of Education, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701-1494, Dr. Jack Christie, Chair, State Board of Education, 12421 Memorial Drive, Houston, Texas 77024, concerning whether the State Board of Education may adopt a rule prescribing general content requirements for textbooks used in public schools, and whether the board's authority over textbook adoption extends to ancillary materials provided by publishers to schools at no cost to the state.

Summary The State Board of Education has no authority under the Texas Education Code to adopt rules regarding the content of state-approved textbooks establishing criteria for approval beyond the criteria contained in §31.023 of the Education Code. The board's authority to adopt or reject textbooks does not extend to consideration of ancillary items provided to school districts free of charge.

DM-426(RQ-897). Request from The Honorable Fred Hill, Chair, Committee on Urban Affairs, P.O. Box 2910, Austin, Texas 78768-2910, concerning whether a housing authority created under Chapter 392 of the Local Government Code is subject to the Open Meetings Act.

Summary A municipal, county or regional housing authority created under Chapter 392 of the Local Government Code is a "governmental body" subject to the Open Meetings Act, Government Code Chapter 551.

DM-430(RQ-909). Request from The Honorable David Sibley, Chair, Senate, Economic Development Committee, Texas State Senate, P.O. Box 12068, Austin, Texas 78711, concerning whether Government Code, §417.0041 delegates rule-making authority to fire protection advisory councils in contravention of the Texas Constitution, Article III, §1.

Summary The delegation of rule-making authority to advisory councils in Government Code, §417.0041 does not contravene Article III, §1 of the Texas Constitution.

TRD-9701583

DM-427(RQ-810). Request from The Honorable James W. Carr, Lavaca County Attorney, P.O. Box 576, Courthouse, Second Floor, Hallettsville, Texas 77964. The Honorable David M. Motley, Kerr County Attorney, County Courthouse, Suite B20, 700 East Main Street, Kerrville, Texas 78028-5324, concerning whether justice courts and municipal courts have jurisdiction of prosecutions under Alcoholic Beverage Code §§106.02, 106.04, and 106.05, which prohibit the possession, consumption, and purchase of alcoholic beverages by persons under the age of 21 years.

Summary The justice courts and the municipal courts to which the Seventy-fourth Legislature's House Bill Number 1648 applies do have jurisdiction of prosecutions for violations of Alcoholic Beverage Code §§106.02, 106.04, and 106.05.

Subsection (b) of §106.115 of the Alcoholic Beverage Code violates state constitutional guarantees of due process and equal protection because it authorizes the imposition of a criminal punishment (community service) in some venues of prosecution (areas in which an alcohol awareness course is not readily available) that is not authorized in other venues. Subsection (b) is therefore invalid, but the other provisions of section 106.115 remain valid and enforceable because they may be given effect without subsection (b).

DM-428(RQ-873). Request from The Honorable Galen Ray Sumrow, Criminal District Attorney, Rockwall County Courthouse, Rockwall, Texas 75087, concerning whether a person may simultaneously serve as a municipal judge in more than one jurisdiction.

Summary A compensated municipal judge, whether full or part-time, elected or appointed, holds a "public office," and is subject to Article XVI, §40, of the Texas Constitution, which prohibits the holding of more than one such office. If he is an appointed municipal judge, he may hold more than one such appointment, provided the holding of the second office is "of benefit to the State." The legislature is

the appropriate body to determine, as a general matter, whether, and under what circumstances, the holding of multiple municipal judgeships is "of benefit to the State." Whether the holding of particular municipal judgeships by a particular individual constitutes a "benefit" to the state requires the resolution of factual matters inappropriate to the opinion process.

DM-429(RQ-872). Request from Becky R. Espino, Chair, Board of Regents, The Texas State University System, P.O. Box 1452, Fort Stockton, Texas 79735, concerning taxation of real property owned by state university and operated as an amusement park.

Summary State-owned property used for public purposes is exempt from taxation. Whether the Aquarena Springs property owned by Southwest Texas State University is subject to ad valorem tax for 1995 involves questions of fact that cannot be resolved in the opinion process.

TRD-9701585

Request for Opinions

ID# 38852. Request from The Honorable Ron Lewis, Texas House of Representatives, P.O. Box 2910, Austin, Texas 78768-2910 concernnig effect of acceptance of certain state funds by a sectarian educational institution.

ID# 39349 Request from The Honorable Hugo Berlanga, Texas House of Representatives, P.O. Box 2910, Austin, Texas 78768-2910 concerning whether a commissioners court must approve the leasing out of its property by a hospital district, and related question.

TRD-9701584

PROPOSED RULES

Before an agency may permanently adopt a new or amended section or repeal an existing section, a proposal detailing the action must be published in the ***Texas Register*** at least 30 days before action is taken. The 30-day time period gives interested persons an opportunity to review and make oral or written comments on the section. Also, in the case of substantive action, a public hearing must be granted if requested by at least 25 persons, a governmental subdivision or agency, or an association having at least 25 members.

Symbology in proposed amendments. New language added to an existing section is indicated by the use of **bold text**. [Brackets] indicate deletion of existing material within a section.

TITLE 4. AGRICULTURE

Part III. Texas Feed and Fertilizer Control Service/Office of the State Chemist

Chapter 65. Commercial Fertilizer Rules

Inspection, Sampling, and Analysis

4 TAC §65.51

The Office of the Texas State Chemist, Feed & Fertilizer Control Service, proposes an amendment to §65.51 to reflect changes in the name of the document referred to and to permit the Service to select alternate methods when such selection is scientifically sound.

Dr. George W. Latimer, Jr., the Texas State Chemist, has determined that for the first five-year period the section is in effect, there will be no financial implications for the Office, state or local government as a result of enforcing or administering the section.

Dr. Latimer has also determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be that the rule is necessary to allow the Service to receive the best possible data on which to base its actions. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the section as proposed.

Comments on the proposed changes may be submitted to Dr. George W. Latimer, Jr., by mail at Office of the Texas State Chemist, P.O. Box 3160, College Station, TX 77841-3160 or FAX (409) 845-1389.

The amendment is proposed under the Texas Agriculture Code, Chapter 63, §63.004, which provides the Texas Feed and Fertilizer Control Service with the authority to adopt rules relating to the distribution of commercial fertilizers.

The Texas Agricultural Code, Texas Commercial Fertilizer Control Act, 4 TAC Chapter 63, Subchapter F, is affected by the proposed amendment.

§65.51. Sampling and Analytical Procedures.

(a) The Service hereby adopts by reference the 16th edition of the *Official Methods of Analysis of the AOAC International* as delineating the sampling and analytical procedures to be applied in the administration of the Act and this title. [The service hereby adopts by reference the official methods of analysis from the Association of Official Analytical Chemists as the sampling and analytical procedures to be applied in the administration of the Act and this title. The methods of analysis are available from the Association of Official Analytical Chemists, 111 North 19th Street, Arlington, Virginia 22209.]

(b) The Service may substitute alternate methods for any AOAC sampling or analytical procedure if it deems the alternate procedure more appropriate to the circumstance and sampling and there is scientific data or reasoning to support the substitution.

(c) Copies of sampling or analytical procedures can be obtained by writing to Office of the Texas State Chemist, P.O. Box 3160, College Station, Texas 77841 or by writing to AOAC International, 481 North Frederick Avenue, Suite 500, Gaithersburg, Maryland 20877.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701446

Dr. George W. Latimer, Jr.

State Chemist

Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist

Earliest possible date of adoption: March 14, 1997

For further information, please call: (512) 845–1121

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TITLE 16. ECONOMIC REGULATION

Part IV. Texas Department of Licensing and Regulation

Chapter 60. Texas Commission of Licensing and Regulation

Subchapter C. Fees

16 TAC §§60.80-60.82

Texas Department of Licensing and Regulation proposes amendments to §60.80 and §60.81 and new §60.82, concerning fees established by the Texas Commission of Licensing and Regulation. The amendments to §60.80 and §60.81 updates the Chapter where individual program fees are published to correspond with legislative changes and establishes new charges for providing copies of public information. The new §60.82 establishes the collection of a processing fee for dishonored checks.

The justification for the amendments to §60.80 and §60.81 are to update the listing of program fees to delete references to programs that are no longer regulated by the department and to amend charges for providing copies of public information to comply with charges adopted by the General Services Commission. The justification for the new §60.82 is to establish a charge for dishonored checks to the department to cover administrative costs.

Jimmy G. Martin, Manager, Consumer Protection Section has determined that for the first five-year period the sections are in effect there will be fiscal implications for state government as a result of enforcing or administering the sections. The effect on state government for the first five year period the sections are in effect will be an estimated increase in revenue of less than $500 per year. There will be no effect on local government.

Mr. Martin also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be increased awareness of cost and service to the public for public records that are not cost prohibitive and reimbursement of administrative costs in handling dishonored checks.

The effect on small businesses and persons who are required to comply with the sections as proposed will be $25 for each dishonored check and minimal fees for copies of public information.

Comments on the proposal may be submitted to Jimmy G. Martin, Manager, Consumer Protection Section, Texas Department of Licensing and Regulation, P. O. Box 12157, 920 Colorado, 8th Floor, Austin, Texas 78711.

The amendments and new section are proposed under Texas Civil Statutes, Article 9100, which authorizes the Texas Department of Licensing and Regulation to promulgate and enforce a code of rules and take all action necessary to assure compliance with the intent and purposes of the Act.

The following are the Articles that are affected by these sections: Section 60.80 - Articles 9100; 8861; 5221f-1; Health and Safety Code, Chapter 754; and Title 2, Labor Code, Subtitle E. Section 60.81 - Articles 9100 and Chapter 552, Government Code. Section 60.82 - Articles 9100 and Chapter 552 Government Code.

§60.80. Program Fees.

Commission set fees are published in the following Chapters:

(1) - (8) (No Change.)

[(9) Chapter 69 of this title (relating to Manufactured Housing);]

(9) [(10)] Chapter 70 of this title (relating to Industrialized Housing and Buildings);

[(11) Chapter 71 of this title (relating to Nonagricultural Public Warehouses);]

(10) [(12) Chapter 72 of this title (relating to Staff Leasing Services);

(11) [(13)]Chapter 74 of this title (relating to Elevators, Escalators, and Related Equipment);

(12)[(14)] Chapter 75 of this title (relating to Air Conditioning and Refrigeration Contractor License Law); and

(13)[(15)] Chapter 78 of this title (relating to Talent Agencies).

§60.81. Charges for Providing Copies of Public Information.

(a) (No change.)

(b) Material fees.

(1) (No change.)

(2) The charge for non-standard size copies is as follows:

(A) (No change.)

(B) **9 - track** [computer] magnetic tape **- $11 each** [- $10];

(C) - (D) (No change.)

(E) **oversized** paper - $.50; [and]

(F) mylar (36-inch, 42-inch, and 48-inch);

(i) **3 mil. - $.85/linear foot;**

(ii) **4 mil. - $1.10/linear foot;**

(iii) **5 mil. - $1.35/linear foot;**

(G) blueline/blueprint paper (all widths) - $.20/linear foot;

(H) [(F)] other - actual cost.

(c)- (e) (No change.)

(f) Computer **resource** fees are as follows:

(1) **Midsize - $1.50 per minute;** [minicomputer/mid-range computing - $3.00 per CPU minute;]

(2) client/server - $2.20 per hour; and

(3) [(2)] PC or LAN computing - **$1.00 per hour.** [$.50 per minute; and]

[(3) on-line access accounts - $.16 per minute.]

(g) - (h) (No Change.)

[(i) FAX fees are as follows:

[(1) local - $.10 per page;]

[(2) Long distance, same area code - $.50 per page; and]

[(3) Long distance, different area code - $1 per page.]

(i) [(j)] A deposit in the amount of the estimated charges will be required for requests exceeding $100 and for on-line access accounts.

(j) [(k)] A personnel fee of $15 per hour may be charged to prepare information for inspection if the information is not readily available or if more than 50 pages of readily available information is requested, or the information must be processed for viewing.

(k) [(l)] The Commissioner may furnish public records without charge or at a reduced charge if it is determined that a waiver or reduction of fee is in the public interest.

§60.82. Dishonored Check Fee.

If a check, drawn to the Texas Department of Licensing and Regulation is dishonored by a payor, the department shall charge a fee of $25 to the drawer or endorser for processing the dishonored check. The department shall notify the drawer or endorser of the fee by sending a request for payment of the dishonored check and the processing fee by certified mail to the last known business address of the person as shown in the records of the department. If the department has sent a request for payment in accordance with the provisions of this section, the failure of the drawer or endorser to pay the processing fee within 15 days after the department has mailed the request is a violation of this section.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 29, 1997.

TRD-9701348
Tommy V. Smith
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: March 14, 1997
For further information, please call: (512) 463–7348

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TITLE 25. HEALTH SERVICES

Part II. Texas Department of Mental Health and Mental Retardation

Chapter 401. System Administration

Subchapter B. Interagency Agreements

25 TAC §401.58

The Texas Department of Mental Health and Mental Retardation (TDMHMR) proposes an amendment to §401.58, concerning Interagency Agreements. The section adopts by reference rules of the Texas Department of Human Services (TDHS) in 40 TAC §72.501 (relating to Memorandum of Understanding Concerning the Capacity Assessment of Persons Who are Elderly and Persons with Mental Retardation and/or Developmental Disabilities) to which TDHS is contemporaneously proposing amendments in this issue of the *Texas Register* .

The TDHS amendments constitute changes to a memorandum of understanding (MOU) between TDHS and TDMHMR as required by the Texas Health and Safety Code, §533.044. The TDHS amendments define who may initiate and administer the assessment tool and require both agencies to: write a final report on the results of the capacity assessment tool pilot study, develop the final version of the assessment tool, and implement use of the tool at nursing facilities which are licensed by TDHS and at residential service facilities which contract with or are operated by TDMHMR.

Donald C. Green, chief financial officer, has determined that for each year of the first five-year period the amendment as proposed is in effect there will be an insignificant expense to state government as a result of administering the provisions of the MOU. Approximately $1,750 per year will be necessary for TDMHMR to cover document printing costs and travel costs for trainers.

Don Gilbert, commissioner, has determined that for each year of the first five years the amendment as proposed is in effect the public benefit anticipated as a result of enforcing the MOU is the provision of a uniform and thorough process for evaluating the need of a individual residing in a residential service facility for a guardianship referral to probate court. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the amendment as proposed.

Written comments on the proposal may be sent to Linda Logan, director, Policy Development, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 30 days of publication. Questions regarding the content of the proposal may be directed to Pat Craig, Longterm Services and Supports, 512/206-4603, or Cynthia Medlin, Consumer Services and Rights Protection, 512/206-5776..

The amendment is proposed under the Texas Health and Safety Code, §532.015, which provides the Texas Mental Health and Mental Retardation Board with broad rulemaking authority, and with §533.044, which requires the MOU to be adopted by rule.

Texas Health and Safety Code, §533.044 is affected by this proposed amendment.

§401.58. Uniform Assessment Tool for Assessing Decision-making Capacity.

(a)-(b) (No change.)

(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, **909 West 45th Street** [4405 North Lamar], Austin, Texas 78756, and may be reviewed during regular business hours.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701498

Ann Utley
Chair, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Proposed date of adoption: April 1, 1997
For further information, please call: (512) 206–4516

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Part XVI. Texas Health Care Information Council

Chapter 1301. Health Care Information Collection and Release of Hospital Discharge Data

25 TAC §§1301.11-1301.19

The Texas Health Care Information Council proposes new §1301.11-1301.19, concerning the collection and release of hospital discharge data. Specifically, the sections define terms used in the collection and release of hospital discharge data; establish rules for collection of hospital discharge data; establish rules for filing discharge reports; establish rules for exemptions from filing requirements; establish rules for acceptance of discharge reports and correction of errors; establish rules for certification of discharge reports; establish rules for hospital discharge data release; and establish rules for discharge reports, including records, data fields, and codes. These new rules will facilitate implementation of the statewide health care data collection system mandated by the Legislature in House Bill Number 1048, of the 74th Legislature, codified in Title 2, Health and Safety Code, §108.1-108.15, to collect health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, good quality health care.

The Texas Health Care Information Council has determined that for the first five-year period the sections are in effect there will be fiscal implications. The costs to state government may average up to $450,000 per year. A portion of these costs may be recaptured through revenues generated by user fees for products produced through implementation of these rules. The revenues to be generated through user fees are expected to be positive but as yet undetermined. There will be no fiscal implications for local governments except to the extent that local governments operate hospitals that are required to submit data per these rules.

The Council has also determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of enforcing and administering the sections will be public access to hospital discharge data regarding health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, good quality health care; to provide an information and data source for providers, consumers, purchasers, and policy makers alike; to promote informed decision making in providing, utilizing, and purchasing health care and for developing and implementing health care policy throughout the state; and to provide a means of benchmarking throughout the state to promote continuous quality improvement by providers to ensure good quality, accessible health care to the citizens of Texas.

There will be additional, marginal costs to providers as they will be required to provide data on all, as opposed to most, patients admitted to their hospitals and the information required is expanded. Few, if any, of the hospitals required to submit data under this rule can be classified as small businesses. The potential for these increased costs have been mitigated by utilizing formats and processes currently in existence and through integration and consolidation with other health care data systems. Under the proposed rule, all hospitals shall file discharge reports by electronic filing (tape, diskette or modem) unless the hospital receives an exemption letter from the Council. The following findings were utilized by the council when writing these rules.

(1) Electronic filing of UB-92 bills with payors by hospitals is the normal business practice in the hospital industry.

(2) Electronic filing of UB-92 bills with payors by hospitals offers significant economic advantages to hospitals and payors in reducing errors, reducing processing costs and speeding payments.

(3) Available computer software and service bureaus usually make electronic filing of UB-92 bills more economical than filing paper UB-92 forms for most hospitals.

(4) Hospitals with the capability to electronically file UB-92 bills with any payor usually have the capability to electronically file discharge files with the council for all patients discharged.

(5) Electronic filing of discharge reports by hospitals to satisfy the council's data collection requirements is less costly for the council and less costly for most hospitals than filing paper UB-92 forms.

The Texas Department of Health, Texas Hospital Association, Blue Cross/Blue Shield, health data organizations in 17 states, and 46 hospitals within the State of Texas were contacted for information regarding provider costs in providing data and information required on uniform billing (UB) form 92 (the format required by these rules). These entities reported a range of costs, from 2 to 3 cents per discharge up to 75 cents per form submitted. For providers that have discharge data bases which are similar to that required for completion of the UB form 92 and which are fully computerized, the cost averages 2 to 3 cents per patient discharged from the hospital; for those that have systems which are not fully computerized or which do not maintain data bases similar to that required for completion of the UB form 92, the cost averages 50-55 cents per hospital discharge; and for those that have little or no computer support and process all claims manually, the cost increases to about 75 cents per hospital discharge. To the extent that hospitals are not currently collecting all of the data required by these rules, they may incur additional costs. Similarly, to the extent that hospitals utilize outside vendors, they may incur additional costs. As a consequence, the financial impact will be most significant on small hospitals with little or no automated data processing capability. For all of the hospitals required to submit data under these rules within the State of Texas, the total cost is expected to be approximately $326,000 per year. There is no anticipated effect on local employment.

Comments on the proposed rules may be submitted to Nelda P. Wray, M.D., M.P.H., Chairperson, Texas Health Care Infor-

mation Council, 4900 North Lamar, OOL-3407, Austin, Texas, 78751-2399, (512) 424-6492. Comments will be accepted for 30 days following publication of this proposal in the *Texas Register*. In addition, a public hearing on the proposed sections will be held at 9:00 a.m., Monday, March 3, 1997, in the Brown-Heatly Building, Room 1410, 4900 North Lamar, Austin, Texas 78751-2399.

A previous version of this proposed rule was published in the August 23, 1996, issue (21 TexReg 7939). Prior to that date, copies of the proposed rule were mailed to all Texas hospitals and other interested parties by the council. A public hearing was held on August 26, 1996, in Austin at which nine people presented oral testimony. During the 30 day comment period following publication of the proposed rule, written comments were received from 53 individuals and organizations. Members of the council have also met informally with representatives of affected interest groups to receive additional input.

Individuals and organizations presenting testimony at the public hearing were: Mr. Ed Berger representing the Seton Health Network, Mr. John Bergin representing St. Joseph's Regional Health Center, Dr. Earl Matthew representing the Texas Medical Association, Mr. Bob Tippens representing Scott & White Hospital and Texas HIMA, Ms. Ann Heiligenstein representing the Conference of Catholic Health Facilities, Ms. Pam McNutt representing Methodist Hospitals of Dallas, Mr. Jay Sherler representing the Providence Health Center, Mr. Joe DaSilva representing the Texas Hospital Association, and Mr. Gary Barton representing HCIA.

Individuals and organizations submitting written comments during the comment period were: Dennis Newquist (Abilene Regional Medical Center); Gerry Brueckner (Baylor Center for Restorative Care); Mark Hood (Baylor Medical Center at Grapevine); Ronald L. Boring (Baylor/Richardson Medical Center); Joel Allison (Baylor University Medical Center); David P. Brown (Citizens Medical Center); Michael Morris (Coleman County Medical Center); Russell Meyers (Columbia Bayshore Medical Center); Richard Harwell (Columbia Navarro Regional Hospital); Sally Jeffcoat (Columbia Spring Branch Medical Center); Norman Powers (Comptroller of Public Accounts); Earl B. Matthew, M.D. (Texas Medical Association); Gary D. Brock (Baylor Medical Center at Garland); Robert A. Pascasio (Memorial Hospital); Judy Huffman (Good Shepherd Medical Center); John Haas (Greater San Antonio Hospital Council); John Froehlich (HCIA), Christy Francis (Hemphill County Hospital); Buddy Edwards (Hillcrest Baptist Medical Center); Ken Blankenship, Robert O. Langland, E.L. Langley, Marilyn Keene-Milligan, Elizabeth R. Propp, and H.J. Macfarland (Irving Healthcare System); John Hornbeak (Methodist Healthcare System); Ann Timpe-Brennan and Lisa L. Dahm (Memorial Hospital System); Pamela G. McNutt (Methodist Hospitals of Dallas); Judy Novak (Park Plaza Hospital); Kent A. Keahey (Providence Health Canter); Robert M. Tippens (Scott & White); W. Edward Berger (Seton); Gail M. Oberta and Mary Klock (Shoal Creek Hospital); Monty McLaurin (St. Joseph's Hospital and Health Center); Susan Rudd Wynn, M.D. (Tarrant County Medical Society); Jim Biltz (Tenet HealthSystem); David R. Smith, M.D. (Texas Department of Health); Jack Harrington (Texas Department of Mental Health and Mental Retardation); Robert M. Tippens (TX HIMA); Jim Houdek, Joe DaSilva and Hugh Lamensdorf, M.D. (Texas Medical Association); James Houdek (Texas Hospital Association); Terry Boucher (Texas Osteopathic Medical Association); Todd Brown (Texas Workers' Compensation Commission); John Mendelsohn. M.D. (The University of Texas MD Anderson Cancer Center); James C. Guckian, M.D. (The University of Texas System); J. Michael Lee (Baylor Medical Center-Ellis County); Richard J. Hausner, M.D. (Harris County Medical Society); Joanne Turnbull (Hermann Hospital); Richard D. Arnold (Medina Community Hospital and Medical Clinics); John G. Bergin (St. Joseph's Services Corporation); Don A. Beeler (St. Michael Health Care Center); John A. Guest (University Health System); and Di M. Dooley (Wilford Hall Medical Center).

The council's hospital discharge data committee discussed the comments at its October 24, 1996, meeting in Houston. The full council discussed the comments and voted on responses to the comments and associated changes to the proposed rule at its meetings on October 28 and November 25, 1996, in Austin. The council determined that sufficient modifications to the proposed rule were required that it would be inappropriate to move to final adoption of a rule without withdrawing the initial proposed rule and publishing a revised proposed rule for public review and comment. Therefore at the January 27, 1997, meeting the council formally withdrew the August 26 proposed rule from further consideration.

In order to document the council's decisions regarding the development of this rule, it has prepared a response to the comments received on the August 26 proposed rule and incorporates them into this preamble. Section references in this response are to the August 26 version of the proposed rule.

Comments Related to Specific Sections of the August 26 Proposed Rule

Section 1301.11 Definitions. The Council accepted comments from the Texas Department of Health (TDH) regarding the need to include TDH in the rule definitions and to conform the definitions of "physicians" and "providers" to those found in the statute. Accepting these comments required creation of another term, "Other Health Professionals," to cover persons who are not "physicians" as defined in the statute, but who may be reported by providers as having admitted or treated patients in certain circumstances.

Concerns were expressed by the Texas Department of Mental Health and Mental Retardation that federal statutes and regulations restricting the release of information on psychiatric and substance abuse patients might prevent hospitals from supplying information on these patients, and thus require changes in the definition of "Inpatient." The council has secured an opinion from TDH legal counsel that no change is necessary to comply with federal law. The relevant law (42 U.S.C. §290dd-2) does not restrict disclosure of records "to qualified persons for the purpose of conducting scientific research, management audits, financial audits or program evaluation...." In the opinion of legal counsel, THCIC comes within this category.

Section 1301.12(b) Number of Discharge Records per Patient. The proposed rule called for one discharge record per patient. This requirement would require hospitals to do additional data processing in four circumstances: (1) for live deliveries where only one UB-92 is currently generated with the mother as

patient, the hospital would be required to generate a second discharge record for the newborn; (2) for patients where the hospital issues interim bills and a final bill, the hospital would be required to create a single consolidated discharge record; (3) for patients moved from an acute care bed to a DRG-exempt unit the hospital would be required to create a single consolidated discharge record; and (4) for patients for which the hospital does not currently generate a bill because of a judgment by the hospital that no payment will occur, the hospital will be required to generate a discharge record when they might not have generated a UB-92. Multiple hospitals objected to the additional data processing required by these aspects of the proposed rule as increasing their costs and being otherwise burdensome. The council responds to these comments as follows:

The proposed rule has been revised to eliminate the requirement that the hospital create a separate discharge record for a healthy newborn if a separate bill was not required by the payor. The council believes that the data elements requested are sufficient to allow the council to create separate discharge records for healthy newborns where necessary. On this point, the revised rule requires the hospital to submit the data in the form required by the payor.

The proposed rule has been revised to eliminate the requirement that for patients where the hospital has issued interim and final bills that those bills be consolidated into a single discharge record. Under the revised rule the council will accept interim and final discharge records and will make the necessary consolidations to produce a single discharge record for analytical purposes. On this point, the revised rule requires the hospital to submit the data in the form required by the payor.

One hospital asked how hospitals were to report patients who were served in the acute care portion of a hospital and were then transferred to a DRG-exempt unit of that hospital. Such units could be skilled nursing units, psychiatric units, comprehensive medical rehabilitation units or long-term care units. The answer depends upon the payor. The majority of these patients are Medicare patients. Medicare requires that the hospital bill separately for the patient's acute care admission and for the admission to the DRG-exempt unit. The hospital should therefore submit to the council a separate discharge record for the admission to each unit or facility. The council will use the data elements on both records to assign a unique patient identifier to provide a clear picture of the overall inpatient episode. Other payors may require the hospital to provide a single bill for the total stay. If so, the hospital would provide the council with one discharge record. We believe the data elements on the record (e.g. revenue codes, conditions and occurrence codes, etc.) will allow proper interpretation of the data for analytical purposes. This approach will minimize any data processing burden on the hospitals. The council has also provided that for each patient record on the public data tapes that acute and subacute care days will be separately reported.

The council does not agree with the comments of numerous hospitals who commented that hospitals should not be required to submit discharge records on self-pay and charity care patients for whom a UB-92 had not been sent to any payor. Some hospitals indicate that such patients are 15% to 25% of their total patients. One hospital commented that it currently uses a vendor to take its data and process the data to the HCFA 1450 format. The hospital pays the vendor a charge per record reformatted. At present only records to be billed electronically are sent to the vendor. Using the vendor to prepare records for the council on patients not currently billed electronically will increase payments to the vendor and hence increase hospital costs. The particular hospital indicates this would increase the number of records processed by its vendor by 20-25%. First, we do not believe that the generation of the required data elements in the proposed rule will, in fact, generate substantial additional expenses for hospitals. The required data elements are ones that hospitals must collect on all patients regardless of payment source (e.g. name, age, diagnosis, procedures, attending physician, disposition at discharge, detailed charges, etc.). These data are utilized for quality assurance, scheduling, medication management and many other operational functions of the hospital. Hospitals do not have one data system for insured patients and a separate data system for uninsured patients. In creating a bill or discharge record for a hospital inpatient, the hospital's data system draws data elements from various data systems in the hospital. The billing system may filter out patients for whom no payor has been identified, but the data is there to create the bill. In fact, many uninsured patients receive bills for inpatient hospital services and the hospital obtains partial, if not total, payment from these patients. The additional expense is likely to be limited to a small additional charge per record from a vendor .

Even if the creation of discharge records for uninsured or charity care patients does generate incremental expense for hospitals, the council believes the expense is justified by the benefit of having a complete data base for the hospital and for the community in which the hospital operates. The Legislature mandated the council to "...develop a statewide health care data collection system to collect health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, good quality health care." (§108.006) We cannot carry out this mandate by looking only at the health service delivered to insured patients when we know that Texas has one of the highest percentages of uninsured patients of any state. We note that the private discharge data system operated by the Texas Hospital Association requires participating hospitals to submit discharge records on all patients.

However, the council believes that it is necessary to specify what data elements are required for each patient. Therefore the council has revised the proposed rule to require submission of a minimum data set (MDS) on all patients. The data elements in this minimum data set closely follow the recommendations of the Texas Hospital Association, with some additional elements necessary for the assignment of unique patient and physician identifiers. The revised rule also requires the submission to the council of all other UB-92 data elements for a patient submitted by the hospital to a third party payor. The council requests that hospitals provide specific, quantitative comments on any incremental data processing problems or financial costs they would incur because of this requirement to submit discharge records on patients for which they do not currently prepare a UB-92 for a payor.

Section 1301.12(c) Provisions Requiring Electronic Filing of Discharge Records. Some hospitals objected to the requirement that discharge records be filed electronically unless the council granted an exemption based on the hospital's inability to file electronically. One commenter suggested the rules as proposed exceeded the council's statutory authority. The council declines to revise the proposed rule in response to these comments. House Bill 1048 clearly gives the council the legal authority to require electronic submission of data in most cases. In §108.009(a) the council is instructed by the Legislature that "The data shall be collected...using electronic data processing, if available. Later in §108.009(l), the Legislature instructs: "The council shall develop by rule reasonable alternate data submission procedures for providers that do not possess electronic data processing capacity." The council interprets §108.009 to require us to collect hospital discharge data by electronic means whenever possible, but to define alternative means for hospitals that do not possess the necessary capacity. §1304.13 of the proposed rule defines three methods of filing discharge reports: (1) tapes or diskette, (2) by electronic data interchange and (3) on paper forms. We have therefore complied with the statute by defining alternative submission procedures for those who cannot file electronically.

This leaves the question of determining which hospitals do not possess electronic data processing capacity. We defined the criteria for answering the question in §1301.15(a)(3). We defined the procedures for a hospital to show it did not possess the capacity to file electronically in §1301.15(b). None of the comments suggested that the criteria or the exemption process were unreasonable or suggested alternatives. We believe the proposed rule follows the statute and requires no revision.

The council reaffirms its findings that electronic filing is the most economical means of data submission for both hospitals and the council. The council requests that hospitals provide specific, quantitative comments on any incremental data processing problems or financial costs they would incur because of this requirement to submit discharge records electronically rather than on paper. The council further requests that if hospitals disagree with the exemption criteria that they explain their disagreement and suggest alternative criteria.

Section 1301.12(d) For a summary and discussion of the comments received on the prescribed data submission format see comments related to §1301.19.

Section 1301.12(g) Review of Hospital Documents and Records. The council wishes to clarify that it has no intention of routinely inspecting hospital documents and records. The reviews covered by this section of the proposed rule would occur only when necessary to verify the accuracy and/or completeness of data submitted by a hospital. One commenter suggested that the council pay the cost of copying any hospital records it requested pursuant to §1301.12(g). The Texas Hospital Association (THA) suggested that this section more closely track the statutory language in §108.007(a) regarding the role of the Texas Department of Health (TDH). Another noted that any reviews of medical records could be costly to the hospital and impose an administrative burden. This section of the proposed rule complies with the statute. Any review of records by the council is in the nature of an audit of the hospital for the enforcement of the statute and the verification of the data. We do not believe it is customary for the State to pay for copies of records in this situation and decline to do so. On the other hand, the council does not propose to charge a hospital for the time or expense of state employees required to conduct a review. We believe the proposed rule provides the "reasonable rules and guidelines" mentioned in the statute. We believe the reference to TDH refers to TDH's duty under §108.008(b)(1) and (2) to assist the council as part of an interagency contract and need not be mentioned in the rule.

Section 1301.13(a) and (b) Schedule for Filing Discharge Reports. One hospital requested that the deadline for submission of the discharge records for a calendar quarter be extended from two months to three months. Several hospitals did not believe they could provide the initial data submission for discharges during the fourth quarter of 1996 because of set-up requirements and a lack of final rule from the council. THA commented that the statute requires the council to test systems for collection of data and to proceed in stages to build the statewide data system. THA recommended that all of 1997 be considered a test period for development of systems. Another hospital requested that hospitals be given a minimum of six months from the time the rules are adopted to prepare to collect the required data.

The council agrees there is a need to build the data system in phases and to test the system. The first phase is the collection of hospital discharge data. We have delayed collection of hospital outpatient and emergency room data and data from other outpatient facilities until this part of the system is operational. We have made provisions for the orderly testing of the system. We cannot begin to test until we have data to test.

The council has revised the proposed rule to provide that no hospital will be required to submit any data until a minimum of 90 days after the effective date of the rule. As test data the proposed rule now requires hospitals to submit a minimum of 30 days and a maximum of 90 days of discharges occurring in the period January 1 to March 31, 1997. The test data must be submitted within 90 days after the effective date of the rule or by May 30, 1997, which ever occurs later. This data will be used only for internal testing. To prevent its release no public use data file will be created from this data (See §1301.18(c)(1)(C)). Data for test purposes is drawn from patient discharges occurring in the first quarter of 1997. Data for discharges occurring in the second quarter of 1997 will not be collected for testing or actual reporting purposes.

The council has further revised the proposed rule to begin collection of discharge data for ultimate release with discharges occurring on or after July 1, 1997. To provide additional time for testing prior to release of public use data, §1301.18(c)(1)(D) provides that data for the third quarter of 1997 will not be released until data for the fourth quarter of 1997 is available which would be in August 1998. This appears to offer ample opportunity for testing and development of the system while not unnecessarily delaying availability of data to state government and the public.

The rule should not require significant information system modifications by hospitals. As revised, the rule requires hospitals to submit for insured patients the social security number and only those data elements already required by the

payors on each specific discharge. For uninsured patients, the revised rule requires only the minimum data set (MDS). The rule does not require the collection of race and ethnicity on discharges before January 1, 1998. (See discussion under §1301.19.) Therefore for discharges during all of 1997, hospitals are being asked to submit National Uniform Billing Committee standard data elements in the HCFA National Standard Format. The only additional data element is the patient social security number

In arriving at the requirement that hospitals submit and certify their discharge records by 60 days after the end of the quarter, the council consulted with the National Association of Health Data Organizations regarding the practices in other states operating similar hospital discharge collection systems. The 60 day period appears reasonable.

Section 1301.13(d) Civil Penalties for Failure to File. The statute at §108.014(b) states, "A person who fails to supply available data under Sections §108.009 and §108.010 is liable for a civil penalty of not less than $1,000 or more than $10,000 for each act of violation. Several commenters felt the mention of civil penalties in the rules was harsh and not consistent with the cooperative environment that the council seeks to develop with health care providers. The council included these references to civil penalties to give fair notice to all concerned of the Legislature's action. The application of such penalties is not automatic. The statute provides that the attorney general would seek such penalties only at the request of the council. The council has no intention of resorting to enforcement actions except as a last resort when all other efforts to obtain cooperation and compliance with the rules have failed. We are mindful that at the start of every data collection program like this there is much trial and error. We are interested in fixing problems, not in fixing blame.

Section 1301.14(a) Magnetic Media. One hospital requested that tape cartridges be listed as an acceptable medium. The council believes the use of certain tape cartridges are accommodated under §1301.14(a)(1)(C). There are many types of tape cartridges and similar storage devices and we need to be sure we have the hardware to read what a hospital chooses to send.

Section 1301.14(a) - (c) Notice of changes in instructions for filing Discharge Reports. Several commenters requested 90 days notice of changes in council procedures instead of the 30 days notice in the proposed rule. This change has been made in the revised rule.

Section 1301.15(a)(1) Exemption as a Rural Provider. Several commenters objected to the section of the proposed rule that requires a hospital to apply for exemption as a rural provider. The commenters observed that the council should be able to use census data to determine which hospitals were eligible for this exemption and notify the hospitals rather than requiring them to file exemption requests.

The council agrees that it can make an initial determination of which hospitals qualify for exemption as a rural provider as new census data becomes available. An initial determination has been made by the State Census Data Center at Texas A&M University. The results will be published by the council. The rule will be revised to indicate that the executive director will make this determination at least annually and notify hospitals as to who is and is not exempt as a rural provider. Hospitals that lose the exemption will be required to begin submitting data for discharges occurring in the next reporting period that begins 90 days or more after the date of notice of loss of the exemption. The council will maintain a procedure where a hospital which believes it has been erroneously denied this exemption can appeal the determination.

Section 1301.15(b) Information Considered by the council in Appeals of Exemption Decisions. One commenter objected to the provision of the exemption appeals procedure whereby in an appeal of the decision of the executive director to the council it will consider only information presented to the executive director. We disagree with this comment. If the hospital has additional information relevant to its exemption that the executive director has not seen, it should first be submitted to the executive director, not to the council. The executive director may change his/her mind on the basis of the additional information, eliminating the need for the council to consider the matter.

Section 1301.16(d) Documentation of Edits. One commenter requested that all edits and acceptance criteria to be applied to discharge reports be incorporated into the text of the rule. The council declines to do so. We do not believe this is practical or required by the Administrative Procedures Act. As stated in the proposed rule we will make copies of all edits and error messages available to hospitals. We will revise the rule to provide computer code only if it is the property of the council.

Section 1301.17(a) Certification of Discharge Reports. Several hospitals commented that the hospital CEO or CFO should not be responsible for certification of the accuracy and completeness of discharge reports. Some indicated the council lacked the statutory authority to require such a certification. We disagree with these comments. We believe §108.007(a) provides the necessary authority. As with other governmental filings we believe a top executive officer of the organization should provide the certification so that there is awareness and accountability by top management. The council has revised the proposed rule by deleting the second sentence.

Section 1301.17(b) Opportunity for Physician Review of Hospital Discharge Records. The Texas Medical Association (TMA) commented that the proposed rule provides the hospital the opportunity to review and verify discharge data, but does not provide the admitting and treating physicians the same opportunity. We have revised this section to require the hospital to provide all their physicians a reasonable opportunity to review the discharge records prior to certification and to file comments along with the certification if a physician disagrees with the hospital concerning the accuracy of a discharge record.

Section 1301.18(b)(5) and (10) Masking of Admission and Discharge Dates. The Texas Workers' Compensation Commission (TWCC) commented that the removal of actual admission and discharge dates from the public use data tape would reduce its utility and recommended leaving exact dates in place. The council declines to accept this comment in order to protect patient confidentiality. Admission and discharge dates will be replaced by length of stay on the public use data tape and a code for day of the week of the admission. Procedure dates will be

replaced by day of stay. Patient birth date will be replaced by age. The user will know in which quarter of what year the discharge occurred. Based on the experience of other state health data commissions, we believe the data, with these substitutions remains very useful and patient confidentiality is enhanced.

Section 1301.18(b)(7) Inclusion of Uniform Patient Identifier on the Public Use Data File. Based on the analysis of comments regarding the inclusion of the uniform patient identifier on the public use data file (see as follows), the council has determined that §108.013(c)(1) precludes us from including the uniform patient identifier in the public use data file because any hospital could use it to deduce the identity of a patient and track the care of that patient at other facilities. While §108.013(b) of the statute seems to suggest that the council give providers access to uniform patient identifiers and have them assign them, we do not intend to do so. Rather, the council intends to generate the list of uniform patient identifiers and match them to newly received discharge records to protect patient confidentiality. We do not believe §108.013(c)(1) precludes the council from utilizing the uniform patient identifier in analysis performed by the council.

Section 1301.18(b)(12) Inclusion of Uniform Physician Identifier on Public Use Data File. Several hospitals commented that there was only one physician at their hospital performing certain procedures and that even if an arbitrary code was utilized that the physician could be easily identified from that code. The commenters expressed concern that confidentiality promised to physicians in the statute may be compromised by the release of physician identifiers through public use data files or through council reports. The council acknowledges the problem raised by the comment. The statute under §108.011(c) requires the council to assign a Uniform Physician Identifier rather than identify a physician by name. Section §108.013(c) then provides that "Unless specifically authorized by this chapter, the council may not release and a person or entity may not gain access to any data...that could reasonably be expected to reveal the identity of a...physician...." Assuming there are situations where a physician's identity could be deduced from the Uniform Physician Identifier, the only specific authorization is found in §108.010(h) which provides: "A quality outcome data report...must identify the physician by the uniform physician identifier...."

Given the public use data file as specified in the proposed rule, any hospital could deduce the Uniform Physician Identifiers for all physicians on its medical staff, thus revealing their identity and enabling the hospital to track the physician's activities at other hospitals. Therefore we will revise the proposed rule to exclude the uniform physician identifier from the public use data file.

Section 1301.18(c)(1) Release of Public Use Data Tapes. Numerous commenters opposed the release of public use data files and/or statistical compilations based on those files. The objections to release of the public use data file to the public apply whether or not the records include quality adjustment factors. A separate set of objections were made to the release of public use data files without quality adjustment factors. The public use data file is often referred to in the comments as "raw data," as if it had not been edited, verified or modified to protect confidentiality. There is concern that the data would be used by unspecified members of the public to produce invalid and misleading analysis that could be used to damage the reputation or competitive position of hospitals and physicians. There were several suggestions that release of public use data tapes either exceeded the statutory authority of the council or was outside the understandings arrived at between legislators and affected stakeholders during negotiations over the statute during the 1995 session.

The council disagrees with the characterization of the public use data file as "raw data." The public use data file will consist of discharge records which have passed the acceptance criteria and edits established by the council. It will consist of discharge records which have been reviewed by the submitting hospital and certified in writing by the CEO or CFO of the hospital as accurate and complete. This certification will come after the hospital's medical staff has been afforded an opportunity to review and correct records on which they are shown as the admitting or treating physician. The public use data file will have been modified only as necessary to meet statutory provisions for confidentiality and to allow risk and severity adjustment. If deemed necessary, the council will have conducted an audit of the discharge records against the hospital's medical record. By no means can one characterize the public use data file as "raw data." The council believes the procedures contained in the proposed rule satisfy the statutory requirement that "The council shall adopt procedures to verify the accuracy of the data before a report containing the data is released to the public."§108.011(d).

The council disagrees with the comments suggesting that such release is not authorized by the statute. The overall thrust of the statute is to make the data collected by the council available to anyone who wants it subject only to specific confidentiality provisions protecting the identity of patients and physicians. The statute makes it a duty of the council to "assure that data collected is made available and accessible to interested persons." §108.006(a)(6). This can best be accomplished by release of a public use data file so that any interested person who wishes can review and analyze the data. The statute also requires that "The council shall promptly provide data to those requesting it, subject to the restrictions on access to council data prescribed by §108.010 and §108.013." §108.011(a). The council is aware of business, labor, educational, research and professional organizations who will request copies of a public use data file or statistical compilations based on that file. The council sees nothing in §108.010 or §108.013 that would restrict this access.

The provisions of the statute concerning confidentiality and general access to data reinforce the view that the council has the obligation to create public use data files from the hospital discharge data and make these files available to the public. The council is required to use data received by the council for the benefit of the public and to make determinations on requests for information in favor of access. The information received by the council, once modified to protect patient and physician confidentiality as required by the statute, is subject to the open records act. §108.013(a).

There have been suggestions that the council create different levels of access to the public use data file for different types of users. For example anyone might have access to a subset of

the data elements on the public use data file, but only qualified researchers would be given access to the full public use data file; perhaps after review of their research plans. This is the practice in some states (e.g. California). Other states make their public use data file available to anyone who wants it and pays the established fee (e.g. Florida). Both approaches have been in operation for several years allowing us to observe the results. The council declines this suggestion because we do not believe that the statute allows us to create different classes of users. The statute requires that "The council shall promptly provide data to those requesting it, subject to the restrictions on access to council data prescribed by §108.010 and §108.013." §108.011(a). Thus any data that is available to any member of the public is available to all members of the public. The council is not allowed to restrict access based on the qualifications of the person or entity requesting the data, or on the purposes for which that person or entity requests the data. Further, we decline the suggestion because we are unable to find examples of harm to any individual caused by giving the public full access to the public use data file.

No commenter has cited any example of any instance where the release of public use data files in other states where such data has been available for many years has resulted in any harm to any provider or any confusion or misdirection of any consumer. Examples cited of controversial uses of data were the HCFA hospital mortality reports, reports of CABG outcomes published by the states of New York and Pennsylvania and a recent report published by the Florida Agency for Health Care Administration. All of these are reports prepared by government agencies, with severity adjustment, review by all providers and all other safeguards. None of these reports were the result of release of public use data files to the public. In fact, most private use of public use data files in other states is internal use of the data by hospitals, employers, insurance carriers and benefit consultants which never results in a published report available to the public. Medical or other scientific research based on public use data files are normally subjected to extensive professional peer review before any publication in a professional journal.

Section 1301.18(c) Release of Public Use Data File Containing Less Than One Year of Data. One commenter objected to the initial release of public use data for only six months because this data file would miss seasonal fluctuations, might have limited numbers of records from small providers and might misrepresent the frequency of rare conditions and procedures. The council disagrees that these are reasons to totally withhold data from the public. We agree that these are valid cautions which should be included in all documentation accompanying the data until a full year is available. However, there are other uses of the data for which we believe six months is adequate (e.g. patient origin and destination patterns, hospital market shares for major diagnostic classifications). Since the statute requires us to resolve policy decisions in favor of public access we do not intend to with hold data that is valid for some common uses because the volume of data may not be sufficient for other uses.

Section 1301.18(c) Format for Public Use Data File. One commenter correctly noted that the public use data file will not be the same as the format in which the data was submitted and requested that the rule specify the format for the public use data file. We disagree with this comment. We do not believe the Administrative Procedures Act requires this sort of information to be adopted in a rule. We note that the Texas Department of Health (TDH) has not adopted rules specifying the format of each and every publication and data file it makes available to the public. The format of the public use data file is a matter to be dealt with in the council's internal procedures. Once established, the council will make the format information available to the public.

Section 1301.18(d) Release of Public Use Data Files Without Quality Adjustment Factors. Numerous commenters expressed concern that hospital discharge data would be released through public use tapes and through requests to the council for statistical tabulations without severity adjustment measures. Some commenters believe it is beyond statutory authority or legislative intent to release data without severity adjustment. There is concern that the data without severity adjustment could be misleading to users and would be used by unspecified members of the public to produce invalid and misleading analysis that could be used to damage the reputation or competitive position of hospitals and physicians. The commenters request that no hospital discharge data be released without severity adjustment scores.

The council will not release any public use data tapes without risk and severity adjustment scores from the risk and severity adjustment systems adopted by the council.

We expect to meet soon with the technical advisory committee named by the council to assist with this process. We have the work of other states which have recently selected severity adjustment programs (e.g. Utah, Florida) on which to build. We anticipate seeking the assistance of an outside contractor to provide the analysis and other staff work in support of the selection process. While we anticipate having to extend the January 1, 1997 deadline for selection of a system, as allowed by statute, we anticipate the selection process can be completed in 1997.

Any severity adjustment system will be a embodied in a computer program that creates one or more severity adjustment scores based on an analysis of patient-specific and facility specific data elements collected from hospitals under this proposed rule. Once the severity adjustment program is selected it will therefore be possible to apply it to all hospital discharge records that have already been collected by the council. Thus any public use data released in August 1998 will include severity adjustment scores that have been thoroughly reviewed and commented upon by all interested parties.

Section 1301.18(f) Provision of copies of Provider-specific Data Requests. One hospital requested that in addition to monthly notice of requests that the executive director's summary should provide list the data requested. This seems unnecessary. All requests for statistical compilations will be in writing and will be maintained by the council for two years. Any person may request a copy of any data request filed.

Section 1301.18(g) Written Comments from Providers. Several commenters noted that the rule did not explicitly provide for release of provider comments on the data along with release of a public use data file or a statistical compilation prepared from that file. We agree that such procedures are necessary.

We will revise the proposed rule by adding subsection (g) to require the executive director to provide all comments submitted by providers relating to any data released.

Section 1301.19(a) Data Format. Comments were received from many hospitals that the format for data submission was non-standard and would require substantial reprogramming of computer systems on the part of Texas hospitals requiring extensive lead time and subjecting them to great expense. The commenters generally requested that hospitals be able to submit data in whatever form they chose, leaving it to the council to translate the data to a standard format. Other comments were received from TDH suggesting that the format in the proposed rule did not correspond to current ANSI-X.12, Medicare or Medicaid formats.

In response to these comments, the council conferred with the Texas Health Information Network (THIN), the electronic bill clearinghouse which is a subsidiary of Blue Cross Blue Shield of Texas (BCBST). THIN receives electronically approximately 60 million health claims per year, including Medicare claims, the majority being from Texas hospitals and physicians. Based upon information obtained from THIN, the council intends to require data to be submitted by Texas hospitals in a standard format which is the same as that in the proposed rule, with minor changes. The reasons for this decision are as follows:

The data format in the proposed rule is the National Standard Format defined by the Health Care Finance Administration for the electronic submission of inpatient hospital bills covering the UB-92 data set (HCFA 1450 flat file, version 4.0).

We will revise the proposed rule to adopt the HCFA format by reference. We will revise the proposed rule to allow hospitals to submit data in the current or immediately preceding HCFA format.

The data format maps the UB-92 data elements and provides unused fields for additional data elements. The council recognizes that some hospital personnel who work with the UB-92 are unfamiliar with the HCFA 1450 data format. The council will make available to anyone requesting it a crosswalk between the elements and the HCFA 1450 format.

No reprogramming of existing hospital data systems is necessary for most hospitals to submit UB-92 data in this data format. The council requests that any hospital that does not have the capability, internally or through a current vendor, to electronically submit inpatient bills in the HCFA 1450 format to identify itself through a comment and explain what cost it would incur to add this capability.

Because the National Standard Format is promulgated by the federal government, the council is able to adopt this format by reference and make provision for automatic incorporation of revisions by the federal government. WE can also increase reporting flexibility by agreeing to accept the current version or the immediately previous version of the National Standard Format.

The council does intend to modify the data format in the proposed rule in the following ways. First, the proposed rule required the patient's social security number to be reported at Record 30, Field 07. This field is defined "Certificate/ Social Security Number/Health Insurance Claim/ Identification Number." For some patients the social security number of the insured party would normally appear here. For other patients, the hospital would have to over write another data item in preparing data for the council. To eliminate this inconvenience, the patient's social security number will be reported at Record 70, Field 28. This field is currently not assigned to any data element. Second, it is possible that a commercial clearing house will be contracted by TDH with the concurrence of the council to perform data collection and editing services. To distinguish records submitted to a clearinghouse for payment from records submitted for reporting to the council, an appropriate code will be reported at Record 01, Field 20.8, Position 183.

Section 1301.19(c) Definition of Data Elements. Comments were received from the Texas Department of Health and from various hospitals that the proposed rule did not adequately define data elements contained in §1301.19. Generally we disagree with these comments because in the proposed rule the data element definitions follow each field. The commenters did not cite specific data elements which they felt were ambiguous or undefined. With a few exceptions discussed as follows, the definitions of data elements that are part of the UB-92 data set are taken verbatim from the National Uniform Billing Data Element Specifications by the National Uniform Billing Committee as published in the latest version of the Texas UB-92 Manual available at the time the proposed rule was published.

Since the publication of the proposed rule, the Congress has passed and the President has signed into law the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). Section 1171(c)(3) extended a formal consultative role to the National Uniform Billing Committee and imposed requirements on the Secretary of the Department of Health and Human Services relative to the use of standards published by National Uniform Billing Committee (NUBC) in carrying out her duties under the act. We note that HCFA is a member of the NUBC and substantially influences its decisions. The Texas State Uniform Billing Committee is an extension of NUBC and does not unilaterally modify its standards. Further, in creating the council the Legislature specifically instructed it to use standards established by the NUBC to the maximum extent possible. Therefore the council believes it can adopt by reference the Texas UB-92 Manual and its future revisions as a source of definitions of data elements not otherwise defined in the council's rules. These revisions have been incorporated in the proposed rule.

The data elements included in the proposed rule that are not part of the UB-92 data set and thus are not covered in the National Uniform Billing Data Element Specifications are THCIC facility identifier, THCIC Uniform Payor Identification Number, source of payment code, patient's social security number, race and ethnicity. (Note that insured's social security number is utilized in the UB-92 data set as the default value for commercially insured patients where a policy ID number is unavailable. See Form Locator 60.)

The council has determined that it is not necessary to require hospitals to supply the THCIC Facility or Payor Identifiers for each discharge. With other data elements that hospitals normally submit to payors the council can assign these identifiers to each discharge record and reduce the burden on the hos-

pitals. Therefore hospitals would enter in the fields where the proposed rule called for these identifiers the data normally submitted to the payor on that patient.

For race (Record 20, Field 2) and ethnicity (Record 20, Field 26) the current definitions specified by the United States Census Bureau were printed in the proposed rule.

The proposed rule utilized a set of codes for "source of payment code" (Record 30, Field 04) which was a modification of a code set utilized by Blue Cross Blue Shield of Texas. The BCBST code set did not include a category for self-pay and did not distinguish all categories of HMO patients. In developing the code set in the proposed rule the council looked to the code set currently in use by the State of Florida in its hospital discharge system and blended the two code sets. We note that the BCBST can be extended to capture all the necessary categories and we have revised the code set in the proposed rule. We have identified the necessary categories and we have revised the code set as shown in §1301.19(c)(4). We have deferred assignment of single letter codes to these categories until adoption of the final rule.

The Texas Medical Association indicated there was a problem in requiring the reporting of bills on workers' compensation patients in a standard format because the Texas Workers' Compensation Commission requires the use of non-standard CPT codes for services. The council is aware of the variation on the standard CPT-4 code set adopted by the Texas Workers' Compensation Commission in its latest Medical Fee Guideline. We do not believe this will be a problem with regard to the hospital discharge data system because procedures on inpatient hospital bills for workers' compensation patients utilize ICD-9 procedure codes. The variance from standard CPT-4 codes only affects bills for outpatient services which are beyond the scope of the proposed rule.

Section 1301.19(c) Required data elements. The proposed rule stated that all data elements were required unless otherwise indicated. Other than comments on collection of social security number, race and ethnicity, we received no comments during the formal comment period concerning which data elements should be required and which should not. However, there have been numerous comments that the data requested in the proposed rule was excessive and burdensome.

We have revised the proposed rule to identify a minimum set of data elements that are required for all patients, regardless of insurance or payment status. In deciding which data elements to require we have considered the lists of required data elements utilized by the current THA patient discharge system and by other state hospital discharge systems. We have considered the data elements required in order to calculate severity adjustment scores. We have considered the minimum data elements required for use of the data by employers, health care providers and public health researchers.

Beyond the required minimum data set for each patient, the rule requires the hospital to submit on each patient all information submitted to the payor(s) for that patient. This data should not be thought of as optional. However, because it will differ from patient to patient, the lack of any data element beyond the minimum required data set will not prevent the discharge record from being included in the council's data base or in the public use data file.

Section 1301.19(e)(3) Patient Data - Collection of Patient Name. One commenter indicated its policy was to redact patient names and replace them with patient account numbers or medical record numbers before releasing data. The collection of patient names is necessary in order to assign a uniform patient identifier that will enable patients to be tracked across multiple admissions to multiple facilities. A patient account or medical record number is unique to the hospital that assigns it and cannot assist in linking a discharge record to another for the same patient. The council believes it has statutory authority to require hospitals to submit this data, just as the Texas Workers' Compensation Commission has for many years, after taking fully into account state and federal confidentiality requirements. We also believe the statute and proposed rules establish sufficient safeguards to patient confidentiality which will be observed by the council in the implementation of its information systems.

Section 1301.19(e)(3) Patient Data - Collection of Social Security Number. Many hospitals objected to the requirement that hospitals collect the patient's social security number. They further objected to identifying the reason no social security number was available for patients without one. Some said this would require additional work by hospital staff. Others said requesting it might be offensive to the patient for various reasons, including it as an attempt to screen out aliens. Hospitals also said the social security number should not be collected because it was not part of the UB-92 data set. The council does not accept these comments.

We believe that almost all hospitals routinely collect the social security number from all patients that have one and enter it into their data systems. No hospital claimed it did not. The objection therefore appears to be more one of releasing the data to collecting it.

We do not believe the statute restricts the council to collection of data elements that are part of the UB-92 data set where the additional data sets are within the general statutory authority of the council to collect. We read the intent of the statute as encouraging us to use UB-92 definitions for data elements found in that data sets rather than creating new definitions which could be confusing.

The council believes the use of the social security number as a patient identifier has become so routine in health care that few, if any, patients could sincerely claim to be offended by the request for this data. We have revised the instructions on what to do if the patient has no social security number because they are not a U.S. resident by taking advantage of the Special Condition code added to the newest edition of the Texas UB-92 Manual, "Patient is non-U.S. Resident" (Form Locator 24-30(25)).

The council understands that social security numbers are not universally available or reliable. However, the council believes that in order to analyze patterns of inpatient hospital use, including transfers, readmissions and movement between acute and non-acute hospital units that it must do its best to construct a uniform patient identifier as defined in the statute §108.002(15)). The council believes that while the social security number is not sufficient standing alone as the uniform

patient identifier, that it is extremely valuable as one of several patient data elements that can be used together to create usable identifiers. Thus, the council believes that the benefits of requiring reporting of the patient's social security number, or the reason it is unavailable, outweigh the costs.

The social security number is part of the minimum data set. The rule requires that the hospital supply either a social security number or a code indicating the reason a number is unavailable. A discharge record would be rejected only if the field was blank or contained invalid characters.

Section 1301.19(e)(3) Patient Data - Collection of Race and Ethnicity Data. Many hospitals objected to the requirement that they be required to collect and report race and ethnicity data on patients. Some objected to the lack of clear definitions of the terms. Some objected to the lack of clear instructions on whether the patient was to be asked to classify himself or herself or whether the hospital staff person was to be required to make a judgment. Some objected that the council did not have statutory authority to collect data elements that were not part of the UB-92 data set. Some felt patients might find the question offensive. Some objected that collecting this information would require reprogramming of data systems, revision of forms and retraining of staff; all at significant expense to the hospitals. One hospital objected that the request for or availability of this data might lead to claims of discrimination.

The code sets for race and ethnicity used in the proposed rule are the standard code sets of the U.S. Census Bureau. It is the intention of the council to revise its code sets for these data elements in the future to be uniform with the Census Bureau. The proposed rule has been revised to clarify that initially the patient, or the person speaking for the patient, is to be asked to make the classification in response to questions from hospital staff. If the patient declines to answer, the hospital staff person is instructed to make the classifications using their best judgment based on available information. If the hospital uses its best judgment, the council has no intention of disputing that judgment. The revised language also provides a statement whereby the hospital may inform the patient that the questions are required by the State of Texas.

The council disagrees with the comment that it lacks statutory authority to require reporting of race and ethnicity as part of the hospital discharge data system. In §108.009(h) we are required to coordinate data collection with the data collection formats used by hospitals and other providers. The NUBC is cited as an example of the publisher of one such format. We note that we have complied with this requirement for data elements defined by the NUBC. However, §108.009(a) gives the council the authority to require reporting of those data it deems appropriate. We are not limited to the UB-92 data set. We would only be outside our statutory authority if the statute forbade us from requiring hospitals to report a data element or if the data element had no reasonable relationship to legislated mission of the council. We do not believe either condition puts us outside our statutory authority with regard to race and ethnicity.

We believe the benefits to the State of collecting data on race and ethnicity outweigh the costs to the hospitals of collecting them. There is a well developed literature that has shown statistically significant differences in the health care provided to racial and ethnic groups for similar medical conditions, even after controlling for insurance status. Some of the differences in health care appear to affect outcomes, while others do not. We believe availability of this data will potentially assist the State in making cost-effective, good quality health care accessible to all Texans.

We disagree that patients will find these questions offensive. The questions have become extremely common. Similar questions appear on census questionnaires, employment applications, certain banking applications, school enrollment applications and vital statistics records. We believe most persons who are members of racial and ethnic minority groups understand the purpose of the questions is to enable government to monitor the actions of various organizations in the community to detect and prevent discrimination.

Unlike social security number, the council acknowledges that race and ethnicity are not part of the UB-92 data set and are not routinely collected by hospitals at present. Time and expense will be required to reprogram computers and train hospital staff to collect this data. In order to prevent the collection of these two data elements from delaying commencement of the overall hospital discharge data system, we have revised the proposed rule to require collection of these data elements on patient discharged on or after January 1, 1998. This delay will also give the 1997 Legislature the opportunity to provide the council guidance on this matter as it sees fit.

Comments not Related to Specific Sections of the Proposed Rule

Duplication of Texas Hospital Association Patient Discharge System. One hospital commented that the proposed rule would duplicate the efforts of THA and also duplicate efforts of the Houston and Dallas Business Groups on Health to build discharge data bases. The commenter suggests coordination to create one quality and outcomes reporting initiative.

We believe a purpose of the statute is to create a hospital discharge data base as part of a broader health care information system that, subject to patient and physician confidentiality provisions, is available to all members of the public. None of the hospital discharge data bases mentioned by the commenter are available to the public as public use data files. All are owned and controlled by private organizations who have not made them generally available to the public and have not proposed to do so.

We see the creation of a statewide hospital discharge data base as eventually eliminating the need for many organizations to create separate proprietary data bases at considerable expense and with considerable duplication of effort. Some of the strongest support for creation of the council came from business and consumer interests who felt it would be more efficient and beneficial to create a central state data base. Outside the largest metropolitan areas, employers do not appear to be able to build their own data systems and thus lack information to guide their health care purchasing decisions. As the council's data base becomes available the organizations currently building data bases will have the opportunity to decide if they need to continue their separate collection efforts, or if

they can rely on the state to collect the data and devote their resources to analysis of the data.

Severity Adjustments Should Consider Teaching Hospital Status. Several commenters noted that the statute §108.010(f) requires any severity adjustment mechanism to consider a hospital's teaching status, and that this was not addressed in the proposed rule. The proposed rule does not specify the severity adjustment mechanism, and is not requires to do so. Since teaching hospital status is hospital-specific and not patient specific, we do not need to include this as a data element on each discharge. The council has access to lists of teaching hospitals which can be utilized when making severity adjustments.

Obligation to provide Consumer Education. Several commenters noted that the council has the duty to provide consumer education and that this was a reason not to release a public use data file. The council does have a broad mission to provide health education information to consumers. This obligation is not specific to hospital discharge data, but also includes HEDIS data and other data elements that may become part of a state health care information system. The council has established a standing committee to develop its consumer education program. We disagree that there is any inconsistency between the council's duty to provide consumer education and the proposed release of public use data files to hospitals, employers, researchers and the general public.

Legal Liabilities Created for Hospitals by Submitting Patient Data. One commenter was concerned that an improper release of data by the council which violated patient confidentiality could create legal liability for the hospital that originally submitted the data. The same concern is expressed with regard to any improper release of data from medical records which was obtained during a data verification effort. We do not believe there is cause for concern on this issue. We do not see a legal basis for anyone to claim a hospital has liability for release of data which was made available to the state in compliance with state and federal statutes and rules. Any liability would lie against the person or entity responsible for the improper release as provided in §108.013. The hospitals should be concerned about liability attaching to them if patient confidentiality was breached as a result of voluntarily submitting data to a private data collection program.

Cost to Hospitals of Compliance. Many commenters took exception to the cost estimates contained in the preamble to the proposed rule. One commenter provided a detailed cost estimate of costs to hospitals which totaled about $17 million per year. We have considered this estimate and do not believe it is reasonable. It ignores the use in the proposed rule of the national standard format and the National Uniform Billing Committee definitions of UB-92 data elements. It ignores the fact that 40% of hospital discharges are Medicare patients whose bills are almost all currently submitted electronically in the national standard format. We have recognized the potential difficulty in collecting data on race and ethnicity and make no current requirement for reporting these elements pending legislative guidance. We have also relieved the hospital of responsibility for assigning a uniform payor identifier or a uniform facility identifier. The commenter was in error in stating that a source of payment code is a new data element. It is currently part of the national standard format. The commenter also asserts that any modification in any data system must be made separately at each Texas hospital. This is incorrect. We expect hospitals will make use of their current arrangements with their corporate parents (e.g. Columbia) and their existing clearinghouse vendors to remap data elements as necessary. The actual number of entities submitting data to the council will be far fewer than the number of hospitals reporting. This substantially reduces the cost of any data system modifications to utilize the national standard format. We would be interested to learn of any hospital billing systems which are currently on the market or in use which are unable to produce an electronic discharge record in the national standard format utilized by Medicare.

Conflict with the Administrative Simplification Provisions of the Kennedy-Kassebaum Legislation. One commenter suggested that Texas suspend implementation of the hospital discharge data system because there might be conflicts with the recently passed Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). We disagree with this comment. Subtitle F of the federal legislation requires the Secretary of Health and Human Services to adopt standards within 18 months of the effective date of the act. The standards will include a format and data elements for health claims or equivalent encounter information which would cover the discharge record defined in the proposed rule. The Secretary must also adopt standards providing a unique health identifier for each individual, employer, health plan and health care provider. (Subtitle F, §1173.)

The council has taken into account the requirements and likely course of implementation of §1173 in drafting the proposed rule. Since HCFA already requires use of the national standard format for billing Medicare, it will be in the interest of the federal government to initially adopt this as the data format for health claims. We believe there is no real alternative to the adoption of the National Uniform Billing Committee definitions of the data elements on the UB-92, and HCFA has had substantial influence on the development of this standard. As an identifier for individual patients, we believe it is reasonable to assume the Secretary will use the social security number, when available, and define an alternative for those without a social security number. We are not requiring hospitals to adopt uniform facility or health plan identifiers. Therefore we do not believe there is adequate reason to postpone carrying out the instructions of the Texas Legislature to develop a hospital discharge data system. We also note that once the standards are adopted by the Secretary, there will be two years allowed for implementation. This will allow ample time for any required revisions to the council's data system.

Adequate Time for Public Comment. Several commenters stated that because of when they had received a copy of the proposed rule and because of the multiple parties within hospitals who needed to review the rule and provide comments that there had not been adequate opportunity for public comment. The council notes that it had several meetings with representatives of THA, (Texas Medical Association) TMA and other interest groups leading up to the publication of the proposed rule. The council took the initiative to call a public hearing and worked with the THA and others to promote distribution of the proposed rules to people who may not regularly read the Texas Register.

Though the time was short between the appearance of the proposed rule in the Texas Register and the public hearing, we believe that by now, all hospitals and most other stakeholders are fully aware of this rulemaking process. Because we are making substantial revisions to the proposed rule, we will republish it and thus open a new comment period. We believe this should alleviate any concerns with the opportunities for public input.

Based upon information provided by the Texas Department of Health, Ronald Luke, chair of the hospital discharge data committee, Texas Health Care Information Council, has determined that for the first five-year period the sections are in effect there will be fiscal implications. The costs to state government may average up to $450,000 per year. A portion of these costs may be recaptured through revenues generated by user fees for products produced through implementation of these rules. The revenues to be generated through user fees are expected to be positive but as yet undetermined. Costs may be less if TDH is able to contract for data collection services at a lower cost than it could perform the services internally. There will be no fiscal implications for local governments except to the extent that local governments operate hospitals that are required to submit data per these rules.

Dr. Luke has also determined that for each year of the first five years the sections are in effect, the public benefits anticipated as a result of enforcing and administering the sections will be public access to hospital discharge data regarding health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, good quality health care; to provide an information and data source for providers, consumers, purchasers, and policy makers alike; to promote informed decision making in providing, utilizing, and purchasing health care and for developing and implementing health care policy throughout the state; and to provide a means of benchmarking throughout the state to promote continuous quality improvement by providers to ensure good quality, accessible health care to the citizens of Texas.

There will be additional, marginal costs to providers. Few, if any, of the hospitals required to submit data under this rule can be classified as small businesses. Almost all Texas hospitals currently have the ability to submit the required data electronically in the required format. Under the proposed rule, all hospitals shall file discharge reports by electronic filing (tape, diskette or modem) unless the hospital receives an exemption letter from the Council. Any costs of submitting data to THCIC may be offset in part by the reduced need for hospitals to pay to participate in private discharge data collection efforts.

The Texas Department of Health, Texas Hospital Association, Blue Cross/Blue Shield, health data organizations in 17 states, and 46 hospitals within the State of Texas were contacted for information regarding provider costs in providing data and information required on uniform billing (UB) form 92 (the format required by these rules). These entities reported a range of costs, from 2 to 3 cents per discharge up to 75 cents per form submitted. For providers that have discharge data bases which are similar to that required for completion of the UB form 92 and which are fully computerized, the cost averages 2 to 3 cents per patient discharged from the hospital; for those that have systems which are not fully computerized or which do not maintain data bases similar to that required for completion of the UB form 92, the cost averages 50-55 cents per hospital discharge; and for those that have little or no computer support and process all claims manually, the cost increases to about 75 cents per hospital discharge. To the extent that hospitals are not currently collecting all of the data required by these rules, they may incur additional costs. Similarly, to the extent that hospitals utilize outside vendors, they may incur additional costs. As a consequence, the financial impact will be most significant on small hospitals with little or no automated data processing capability. For all of the hospitals required to submit data under these rules within the State of Texas, the total cost is expected to be approximately $326,000 per year. There is no anticipated effect on local employment.

The new sections are proposed under the Health and Safety Code, §108.6-108.13, which provide the Texas Health Care Information Council with the authority to establish rules to implement and administer a state-wide health data collection system.

These new sections affect Health and Safety Code, Chapter 108.

§1301.11. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

Batch file- A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) which contains one or more discharge files and other required header and trailer records. A batch contains discharge files for only one hospital.

Charge - The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules or write-offs for charity care, bad debt or administrative courtesy. The term does not include co-payment charges to a health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization.

Council - The Texas Health Care Information Council.

Discharge - The formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death or by disposition to a residence or another health care provider.

Discharge file - A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) relating to a specific patient. Except for some normal newborn infants there will be one or more discharge files for each inpatient.

Discharge report- A computer file as defined in § 1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) periodically submitted on or on behalf of a Hospital in compliance with the provisions of this chapter.

Electronic filing -The submission of computer records in machine readable form by modem transfer from one computer to another or by recording the records on a nine track magnetic tape, computer diskette or other magnetic media acceptable to the executive director.

Error - Data submitted on a discharge report which are not consistent with the format and data standards contained in this rule or with editing criteria established by the executive director, or the failure to submit required data.

Executive director - The chief administrative officer of the council, or, in the event the council is without an executive director, the person designated by the chairperson of the council to perform the functions and exercise the authority of the executive director.

Facility identifier - A unique number assigned by the council to each health care facility in the state. For hospitals this will be the hospital's state license number. Where a hospital operates multiple facilities under one license number, the council will assign a suffix for each separate facility.

Health care facility - A hospital, an ambulatory surgery center licensed under Chapter 243 of the Health and Safety Code, a chemical dependency treatment facility licensed under Chapter 464 of the Health and Safety Code, a renal dialysis center, a birthing center, a rural health clinic or a federally qualified health center as defined by 42 United States Code, §1396(1)(2)(B).

Hospital - A public, for-profit, or nonprofit institution licensed or owned by this state that is a general or special hospital, private mental hospital, chronic disease hospital or other type of hospital.

Geographic identifier - A set of codes and accompanying maps prepared by the Council covering Texas and adjacent states with each code consisting of two or more zip codes, a set of codes and accompanying maps prepared by the council covering the rest of the United States consisting of three digit zip codes, a set of codes and accompanying maps prepared by the council covering Canada and Mexico consisting of a separate code for each state or province and a set of codes for each of the other countries.

Inpatient - A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, subacute, skilled nursing, long-term, psychiatric, substance abuse, physical rehabilitation and all other types of hospital units.

Other health professional - A person licensed to provide health care services other than a physician. An individual other than a physician who admits patients to hospitals or who provides diagnostic or therapeutic procedures to inpatients. The term will encompass persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists and podiatrists who are authorized to admit or treat patients.

Patient control number - A number assigned to each patient by the hospital which appears on each computer record in a patient discharge file. This number is not consistent for a given patient from one hospital to the next, or from one admission to the next in the same hospital. The council deletes or encrypts this number to protect patient confidentiality prior to release of data.

Physician - An individual licensed under the laws of this state to practice medicine under the Medical Practice Act (Vernon's Texas Civil Statutes, Article 4495b).

Provider - A physician, health care facility or health maintenance organization.

Public use data file - A data file composed of discharge files with risk and severity adjustment scores which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of hospital discharge data imposed by statute.

Required minimum data set- The data elements which hospitals are required to submit in a discharge file for each inpatient regardless of whether or not the hospital would have prepared a bill for the inpatient. The required minimum data set is specified in §1301.19(e) of this title (relating to Discharge Reports - Records, Data Fields and Codes).

Rural provider - A provider located in a county with a population of not more than 35,000 according to the most recent United States Bureau of the Census estimate, those portions of extended cities that the United States Bureau of the Census has determined to be rural, or an area that is not delineated as an urbanized area by the United States Bureau of the Census.

Submission - A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) that constitutes the discharge report for one or more hospitals.

Submitter - The person or organization which physically prepares discharge reports for one or more hospitals and submits them to the council. A submitter may be a hospital or an agent designated by a hospital or its owner.

Uniform patient identifier - A random number assigned to an individual patient which remains constant across hospitals and inpatient admissions.

Uniform payor identifier - A unique number assigned by the council to every third party payor of UB-92 bills. Where ever possible the council will use established numbering systems such as that maintained by the National Association of Insurance Commissioners.

Uniform physician identifier-A unique number assigned by the council to any physician or other health professional who is reported as admitting or treating a hospital inpatient which remains constant across hospitals.

§1301.12. Collection of Hospital Discharge Data.

(a) All hospitals in operation for all or any of the reporting periods described in §1301.13 of this title (relating to Schedule for Filing Discharge Reports) shall submit discharge files on all inpatients to the Council. Hospitals owned by the federal government and hospitals exempted as rural providers may submit hospital discharge files.

(b) All inpatient discharges shall be reported. Except as noted as follows, one or more discharge files shall be submitted for each patient for each discharge covering all services and charges from admission through discharge.

(1) Separate discharge files shall normally be submitted for mothers and newborns. Hospitals are not required to create a separate discharge file for a normal newborn infant if the delivery is covered by a third party payor and the third party payor does not require separate bills for the mother and the infant. For any birth where there is no third party coverage, separate discharge files are required for the mother and the infant.

(2) Where a hospital has issued interim and final bills covering a single patient discharge, the hospital shall submit separate discharge files corresponding to each bill.

(3) Where a patient has been served in multiple units of a hospital (e.g. acute care, skilled nursing care, comprehensive medical rehabilitation, substance abuse) during a single continuous stay, some third party payors require that separate bills be prepared for services in acute and sub-acute units while others do not. Where a patient has third party coverage, the discharge files submitted by the hospital shall correspond to the bills submitted to the payor. Where a patient has no third party coverage, the hospital shall submit a separate discharge file for each unit.

(4) For all patients for which the hospital prepares one or more bills for inpatient services, the hospital shall submit a discharge file corresponding to each bill containing the required minimum data set and all other data elements included on the bill whether included because of the requirements of third party payors or because of hospital policy. For all patients for which the hospital does not prepare a bill for inpatient services, the hospital shall submit a discharge file containing the required minimum data set.

(c) All hospitals shall file discharge reports by electronic filing unless the hospital receives an exemption letter from the Council.

(d) All hospitals shall submit discharge files and discharge reports in the format specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes).

(e) Hospitals shall submit discharge reports, data certifications, exemption requests and other required information to the council or its agents at physical or telephonic addresses specified by the executive director. The executive director shall notify all hospitals and submitters in writing and by publication in the *Texas Register* at least 30 days before any change in the addresses.

(f) Hospitals may submit discharge reports, or may designate an agent to submit the reports. If a hospital designates an agent, it shall inform the council of the designation in writing at least 30 days prior to the agent's submission of any discharge report. The hospital shall inform the council in writing at least 30 days prior to changing agents or making the submissions itself. Designation of an agent does not relieve the hospital of responsibility for compliance with this chapter or other related law.

(g) If requested by the council, a hospital shall provide the executive director and his agents access to, copies of and/or information from the hospital documents and records underlying and documenting the discharge reports submitted, as well as other patient related documentation deemed necessary to conduct audit hospital data to verify its accuracy and reliability. Each request from the council shall detail the reasons for such request, provide the hospital with at least 14 days advance notice, and ensure that confidentiality of patient records is maintained.

§1301.13. Schedule for Filing Discharge Reports.

(a) For discharges occurring on or after July 1, 1997, hospitals shall file discharge reports according to the following schedule unless a hospital has received an exemption letter from the council.

(1) Each discharge report covering inpatient discharges occurring between January 1 and March 31, inclusive, shall be submitted no later than June 1 of the calendar year in which the discharge occurred.

(2) Each discharge report covering inpatient discharges occurring between April 1 and June 30, inclusive, shall be submitted no later than September 1, of the calendar year in which the discharge occurred.

(3) Each discharge report covering inpatient discharges occurring between July 1 and September 30, inclusive, shall be submitted no later than December 1 of the calendar year in which the discharge occurred.

(4) Each discharge report covering inpatient discharges occurring between October 1 and December 31, inclusive, shall be submitted no later than March 1 of the year following the year in which the discharge occurred.

(b) On or before May 30, 1997, hospitals shall submit a discharge report drawn from inpatient discharges occurring between January 1, 1997 and March 31, 1997, inclusive. This discharge report shall be used for test and certification purposes only. The discharge report may include all discharges for the quarter, but the hospital is only required to submit discharge files covering discharges for any consecutive 30 days of the quarter.

(c) Extensions to processing due dates may be granted by the executive director for a maximum of ten working days in response to a written request signed by the hospital's chief executive officer. Requests must be in writing, must be received at least five working days prior to the due date and must be accompanied by adequate justification for the delay.

(d) Failure to file a discharge report on or before the due date without an extension, is punishable by a civil penalty pursuant to Health and Safety Code, §108.14.

(e) The other provisions of this section not withstanding, no hospital shall be required to file a discharge report sooner than 90 calendar days after the effective date of this rule.

§1301.14. Instructions for Filing Discharge Reports.

(a) Magnetic Media - A discharge report may be filed on computer diskettes, nine track tapes or other magnetic media approved by the executive director. All discharges shall be reported using the same file and record formats specified in §1301.19 regardless of medium.

(1) Media specifications are:

(A) Diskette: MS-DOS formatted; PC Text file (ASCII); Record length = 192 characters, fixed; 3.5 inch diskette, 1.4 megabyte, high density.

(B) Nine track tape: Density = 1600 or 6250 BPI, nine track; Collating sequence = EBCDIC or ASCII; Record length = 192 characters, fixed; Blocking = unblocked; Labeling = no label.

(C) Other magnetic media: Discharge reports may be filed on other magnetic media only with the prior written approval of the executive director. The executive director will not normally approve any medium which the Council is not currently equipped to read.

(2) Hospitals shall submit no more than one tape or two diskettes per submission, with the following external identification affixed:

(A) Hospital name.

(B) Facility identifier.

(C) Reporting period for discharges.

(D) Number of records by record type.

(E) Tape density: 1600/6250 BPI (if applicable).

(F) Collating sequence for tapes (if applicable).

(G) The description: "DISCHARGE DATA".

(3) Data for more than one hospital may be submitted on a single tape if the submitter provides external identification items in paragraph (2)(A)-(D) of this section for each hospital.

(4) In addition to the provisions of this section, the council shall document instructions for filing discharge reports on magnetic media and shall make this documentation available to hospitals at no charge and to the public for the cost of reproduction. The council shall notify hospitals or their designated agents at least 90 days in advance of any change in instructions for filing discharge reports on magnetic media. The council's instructions shall follow Department of Information Resources standards for magnetic media established under Chapter 201 of this Title.

(b) Electronic Data Interchange: Discharge reports may be filed by modem using electronic data interchange (EDI). All discharges shall be reported using the same file and record formats specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) regardless of the medium of transmission. Record length is 192 characters for all records. The council shall document instructions for filing discharge reports by EDI and shall make this documentation available to hospitals at no charge and to the public for the cost of reproduction. The council shall notify hospitals and their designated agents at least 90 days in advance of any change in instructions for filing discharge reports by EDI. The council's instructions shall follow Department of Information Resources standards for EDI.

(c) Paper Forms: Only hospitals granted an exemption from electronic filing of discharge reports may file discharge reports using paper UB-92 billing forms. Hospitals using paper forms are required to provide all data elements specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes).

(1) All UB-92 forms filed shall be on the form currently approved by the federal Health Care Finance Administration. Photocopies are not acceptable.

(2) Hospitals shall submit no more than one batch of paper forms per submission, with the following external identification affixed:

(A) Hospital name;

(B) Facility identifier;

(C) Reporting period for discharges;

(D) Number of forms; and

(E) The description: "DISCHARGE DATA".

(3) In addition to the provisions of this section, the Council shall document instructions for filing paper UB-92 forms and shall make this documentation available to hospitals at no charge and to the public for the cost of reproduction. The council shall notify hospitals or their designated agents at least 90 days in advance of any change in instructions for filing paper forms.

§1301.15. Exemptions from Filing Requirements.

(a) Types of Exemptions

(1) Exemption as a Rural Provider - All hospitals except those owned by the federal government shall submit discharge reports to the council unless the council determines that the hospital is a rural provider. The executive director shall make a determination of which hospitals are entitled to this exemption at least annually and shall notify qualifying hospitals by publication in the Texas Register and by regular United States mail. Hospitals which are not initially given an exemption may apply for an exemption. This exemption, if granted, may be revoked by the council should the hospital cease to meet the criteria for exemption based upon the most current data issued by the United States Bureau of the Census. Hospitals that cease to be exempted as rural providers shall be responsible for submitting discharge files on all discharges that occur 30 days after notice is given. The initial discharge report shall not be due until 90 days after notice is given. Subsequent discharge reports are due as specified in §1301.13(a) of this title (relating to Schedule for Filing Discharge Reports).

(2) Exemptions from Quarterly Filing of Discharge Reports - Hospitals that wish to submit discharge reports to the council more often than quarterly may do so by requesting an exemption to the standard submission schedule. The council may also issue general exemptions based on the processing arrangements for data collection. Exemption requests meeting the following criteria will normally be approved.

(A) The exemption request includes the specific schedule on which the hospital will make its discharge reports which will usually be daily, weekly or monthly.

(B) The exemption request states the medium in which submissions will be made.

(C) The exemption request will not result in data on any discharge being submitted to the council at a later date than it would have been if the standard schedule been followed.

(D) The hospital agrees to adhere to the schedule specified in the exemption request until the hospital notifies the executive director in writing that it wishes to end the exemption and report according to the standard schedule, or until a new exemption letter is issued.

(3) Exemption from Electronic Filing of Discharge Reports - The council will grant exemptions from electronic filing of discharge reports only when a hospital can demonstrate that it lacks electronic data processing capacity and that electronic filing of discharge reports imposes an unreasonable financial burden upon the hospital. If granted, the exemption is valid for one year and must be renewed annually by the hospital. The exemption from electronic filing of discharge reports does not change the data the hospital is required to file on each discharge as specified in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes), nor the schedule for submission specified in §1301.14 of this title (relating to Instructions for Filing Discharge Reports). Exemptions from electronic reporting to the council will not normally be granted unless

(A) the hospital shows that it does not currently electronically file UB-92 bills with any payor, or has not done so in the last 12 months prior to the request for exemption; and

(B) the hospital shows that it could not cost-effectively submit UB-92 bills electronically to its payors and to the Council utilizing internal staff or utilizing contractors for this function.

(b) Requests for exemptions shall be submitted and processed using the following procedures.

(1) A hospital requesting an exemption shall submit to the executive director a letter requesting the exemption and providing all information necessary to establish the hospital's entitlement to the exemption. The exemption request shall be signed by the chief executive officer of the hospital who shall certify that all information contained in the request is true and correct.

(2) The executive director shall review the request for exemption. The executive director may request additional information from the hospital relevant to the exemption request. Within 30 days of receipt of a request, the executive director shall issue a letter granting or denying the exemption. If denied, the letter shall state in detail the reasons for the denial. The executive director shall notify council members of exemptions requested and the disposition of these requests for information only.

(3) If the executive director denies an exemption request the hospital may

(A) Resubmit the request along with any additional information or analysis the hospital deems relevant to the executive director. The resubmission shall be considered in the same manner as an initial submission; or

(B) Appeal the executive director's decision to the council. The hospital may make an appeal directly to the council. In making its determination, the council will consider only those facts and issues which have been previously presented to the executive director. The council will decide exemption appeals by majority vote of members present.

(4) The executive director may revoke any type of exemption if facts indicate that a hospital no longer meets the criteria required for an exemption. The executive director shall give the hospital written notice of the revocation at least 30 days prior to the effective date of the revocation. The notice shall include a detailed statement of the facts on which the revocation is based. A hospital may challenge the revocation of its exemption by:

(A) Requesting the executive director to reconsider the revocation by submitting any information or analysis the hospital deems relevant to the executive director in writing at least ten days prior to the effective date of the revocation; and

(B) If the executive director does not agree that the exemption should continue, by appealing the executive director's decision to the council. In making its determination, the council will consider only those facts and issues which have been previously presented to the executive director. The council will decide exemption appeals by majority vote of members present.

§1301.16. Acceptance of Discharge Reports and Correction of Errors.

(a) To verify the accuracy of all discharge files prior to public release, the executive director shall establish procedures for the review of all discharge reports to determine whether the report is acceptable, as required by Health and Safety Code, §108.11.

(b) Upon receipt of a discharge report, the executive director shall determine if it satisfies minimum criteria for processing. If it does not, the executive director shall return the report and state the deficiencies in writing within ten days of receipt. The hospital shall resubmit the report within ten days of notification by the executive director. A discharge report does not meet minimum standards for processing under the following circumstances.

(1) The physical media and labeling do not conform to the specifications in §1301.14 of this title (relating to Instructions for Filing Discharge Reports).

(2) The physical media are unreadable due to physical damage.

(3) The file structure does not conform to the specifications in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes).

(c) Correction of Errors

(1) The executive director shall review all discharge reports accepted for processing and will process all discharge files against the editing criteria established by the this rule and by the executive director. Within 30 days of receipt of an accepted discharge report the executive director shall notify the hospital in detail of all errors detected in the discharge report.

(2) Within 30 days of receiving initial notice of errors in a discharge report, the hospital shall correct all discharge files containing errors, add any discharge files determined to be missing from the initial discharge report and resubmit the discharge files. If the hospital disagrees with any identified error, the hospital shall submit written justification of the correctness or completeness of its data. Each hospital shall submit such modified and/or additional discharge files as may be required to allow the chief executive officer or chief financial officer to certify the discharge report as required by §1301.17 of this title (relating to Certification of Discharge Reports). Corrections to a discharge report shall be submitted in the same medium and format as the original discharge report unless the executive director approves another medium.

(3) Within ten days of receiving corrections to a discharge report from a hospital, the executive director shall notify the hospital of any remaining errors. The hospital shall have ten days from receipt of this notice to correct the errors noted or submit a written explanation of why the data should be deemed correct and complete. This process shall be repeated until the executive director is satisfied that the data submitted by the hospital is substantially accurate and until the hospital is able to certify the discharge report as required by §1301.17 of this title (relating to Certification of Discharge Reports).

(d) The executive director will document and the council will approve all acceptance and editing criteria utilized in reviewing discharge reports. If acceptance and editing criteria are incorporated into computer software, and if the software is the property of the council, the executive director will make copies of the portions of the software containing the criteria available on paper or magnetic media. The executive director will shall make this information available to submitters without charge and to others for the cost of reproduction.

(e) Failure to correct a discharge report which has been filed but contains errors or omissions within the due dates in §1031.13 of this title (relating to Schedule for Filing Discharge Reports) is punishable by a civil penalty pursuant to Health and Safety Code, §108.14.

§1301.17. Certification of Discharge Reports.

(a) The chief executive officer or the chief financial officer of each hospital shall certify that the discharge report for each quarter is accurate using forms supplied by the council.

(b) The certification shall represent that a complete review of hospital records was accomplished to assure the accuracy of the discharge report and any corrections submitted, that all errors and omissions known to the hospital have been corrected, and that to the best of their knowledge and belief, the data submitted is accurate and complete. The certification shall also represent that the hospital has provided physicians and other health professionals on its medical staff a reasonable opportunity to review the discharge files for which they were the admitting or treating physician or other health professional prior to certification, have corrected any errors brought to the hospital's attention and have included with the discharge report any comments on the accuracy of the data submitted by physicians or other health professionals. Written explanation of any unresolved disagreements with the executive director concerning the accuracy and completeness of the data at the time of the certification shall be attached to the certification form.

(c) Each hospital must file its certification of each quarter's data with the council within six months following the last day of the reporting quarter. Extensions to this period will not be granted.

(d) Failure to timely file a certification of discharge data previously submitted is punishable by a civil penalty pursuant to Health and Safety Code, §108.14.

§1301.18. Hospital Discharge Data Release.

(a) Council records are public records under Government Code, Chapter 552, except as specifically exempted by Health and Safety Code, §108.10 and §108.13, and are available for public inspection during normal business hours. Copies of such records may be obtained upon request and upon payment of user fees established by the council. Discharge files in the original format they are submitted to the council are exempt from disclosure pursuant to Health and Safety Code, §108.10 and §108.13, and shall not be released. Likewise, patient specific data collected by the council through audits of hospital data shall not be released.

(b) Creation of public use data file - The executive director will create a public use data file by creating a single record for each inpatient discharge and adding, modifying or deleting data elements in the following manner:

(1) Delete patient and insured name, address, certificate and social security data elements. Delete patient control and medical record numbers. Assign geographic identifier and county code.

(2) Convert patient birth date to age.

(3) Convert admission and discharge dates to a length of stay measured in days and a code for the day of the week of the admission.

(4) Convert procedure and occurrence dates to day of stay values.

(5) Delete physician and other health professional names and numbers.

(6) Convert payor names and identification numbers to uniform payor identifiers.

(7) Convert employer name and address data to a Standard Industrial Classification Code.

(8) Delete provider name address and identification numbers. Assign facility identifier.

(9) Convert all procedure codes to ICD-9-CM.

(10) Add risk and severity adjustment scores.

(c) Release of files and statistical compilations based on the public use data file. The council shall promptly provide data to those requesting it, subject to restrictions imposed by Health and Safety Code, §108.10 and 108.13 as interpreted by the council's rules.

(1) The executive director will make available a public use data file on magnetic media for each quarter not later than seven months after the end of the quarter.

(A) The executive director shall release discharge files from hospitals that have certified the data as required by §1301.17 of this title (relating to Certification of Discharge Reports). A hospital's failure to execute the certification form after six months shall not prevent the executive director from releasing the hospital's data if he believes the data submitted is reasonably accurate and complete. The executive director shall not include in the public use data file records derived from hospital discharge files which contain material errors. The executive director will include with the public use data file information on the number of discharge files received from each hospital and the number of discharge files from each hospital included on the public use data file.

(B) If additional discharge files become available after the initial release of the public use data file for any quarter, the executive director will add these records to the public use data file and make the additional records available to the public.

(C) The other sections of this rule not withstanding, the executive director shall not create a public use data file from the discharge reports covering discharges occurring in the first or second quarters of 1997. It is the intent of the council to utilize this data only for testing and calibration of its data processing systems and to allow hospitals the opportunity to test and calibrate their own data reporting systems.

(D) The other sections of this rule not withstanding, the executive director shall not create or release a public use data file from discharge reports covering discharges for the third quarter of 1997 until a public use data file covering discharges for the fourth quarter of 1997 is created and released. The council will initially release six months of data in order to provide a more reliable body of data for analysis and decision-making and to make available public use data files on a quarterly schedule thereafter.

(2) The public may request the executive director to prepare statistical compilations based on public use data files. The executive director will take the steps necessary to fill these requests by providing the public with on-line access to public use data files and statistical report software and by preparing statistical compilations to user specifications.

(3) The council shall establish standard forms for ordering public use data files and statistical compilations based on public use data files. The council shall provide for computer to computer access to allow persons to make requests using electronic mail and to download public use data files and statistical compilations based on public use data files. The council shall also fill requests on magnetic media and on paper as specified by the requestor. The council's service standard shall be to normally fill requests within five working days of receipt of the request and payment for the request. The executive director shall establish procedures to accommodate standing orders for recurring requests.

(4) The council shall adopt a fee schedule for filling requests for public use data files and statistical compilations based on public use data files, and shall update this fee schedule at least annually. In adopting a fee schedule the council shall strike a reasonable balance between the statutory goals of improved public access to health care data (Health and Safety Code, §108.013(a)), and the goal of providing part of the costs of operation of the council through user fees (Health and Safety Code, §108.12(b)). The executive director shall establish procedures for providing price quotations to requestors and for collecting user fees prior to filling requests. These procedures may include the establishment of advance deposit accounts by requestors. This fee schedule may include restrictions on distribution, republication or reuse of the data in ways that would diminish user fees to the Council.

(5) The council shall not charge Texas state agencies a fee for data requested solely for the internal use of the agency to comply with Health and Safety Code, §108.12(b). Prior to filling the request of a state agency without fee, the executive director shall secure an interagency agreement imposing restrictions on distribution, republication or reuse of the data in ways that would diminish user fees to the council.

(6) The executive director shall establish procedures for screening all requests to assure that filling the request will not violate the provisions of Health and Safety Code, §108.13(c).

(d) The data elements specified for discharge reports in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes) do not constitute "Provider Quality Data" as discussed in Health and Safety Code, §108.10. Statistical compilations compiled from public use data files may be released with or without either discharge-specific or aggregate provider quality data. Statistical compilations without provider quality data are not subject to the restrictions imposed on the council by Health and Safety Code, §108.10. Public use data files and statistical compilations compiled from public use data files with provider quality data may only be released subject to the restrictions in Health and Safety Code, §108.10, and rules adopted by the council to implement this section of the statute.

(e) A public use data file or a statistical compilation compiled from public use data files which is specified by the requestor shall not be considered a "report issued by the Council" as referenced in Health and Safety Code, §108.11(f). No opportunity for review or comment by providers whose discharges may be included in the file or statistical compilation is required prior to release of the data to the requestor.

(f) Requests for data files and statistical compilations based on public use data files including data on one or more provider are matters of public record and copies of all requests shall be maintained by the council for two years from the date of receipt. The executive director will transmit monthly a summary of all requests received to all hospitals submitting discharge data to comply with Health and Safety Code, §108.11(e).

(g) With any public use data file or any statistical compilation prepared by the council, the executive director shall attach all comments submitted by providers which relate to any data included in the file or compilation.

§1301.19. Discharge Reports - Records, Data Fields and Codes.

(a) Discharge reports shall be submitted in the national standard flat file format for inpatient hospital bills defined by the United States Department of Health and Human Services, Health Care Finance Administration (HCFA); commonly known as the HCFA 1450. HCFA updates this format from time to time by issuing new versions. The council will accept discharge reports in the latest version or in the immediately preceding version. At the effective date of this rule, the latest version was version 4.1 and the immediately preceding version was version 4.0. The council will make detailed specifications for these formats available to submitters and to the public.

(b) Except as otherwise provided in this section, discharge reports shall be submitted using the national uniform billing data element specifications as developed by the National Uniform Billing Committee (NUBC) as published by the State Uniform Billing Committee (SUBC) with instructions specific to Texas third party fiscal intermediaries in the Texas UB-92 Manual. The NUBC revises these data element specifications from time to time and the SUBC publishes revisions showing the effective date for changes to each data element. Hospitals shall submit discharge reports using the data element specifications in effect as of the date of the discharge. The council will make detailed specifications for these data elements available to submitters and to the public.

(c) In addition to the data elements contained in the Texas UB-92 Manual, the council has defined the following data elements and has defined the location in the HCFA 1450 format where each element is to be reported.

(1) Patient Race - This data element shall be reported at Record Type 20, Field 02, Beginning Position 03 as a numeric value. Acceptable codes are 1=American Indian/Eskimo/Aleut, 2 = Asian or Pacific Islander, 3 = Black, 4 = White and 5 = Other. In order to obtain this data, the hospital staff is to ask the patient, or the person speaking for the patient to classify the patient. If the patient, or person speaking for the patient, declines to answer, the hospital staff is to use its best judgment to make the correct classification based on available data.

(2) Patient Ethnicity - This data element shall be reported at Record Type 20, Field 26, Beginning Position 190 as a numeric value. Acceptable codes are 1 = Hispanic Origin and 2 = Not of Hispanic Origin. In order to obtain this data, the hospital staff is to ask the patient, or the person speaking for the patient to classify the patient. If the patient, or person speaking for the patient, declines to answer, the hospital staff is to use its best judgment to make the correct classification based on available data.

(3) Patient Social Security Number - This data element shall be reported at Record Type 30, Field 07, Beginning Position 35 as a numeric value. In the event the patient is a newborn or child of United States citizenship for whom a social security number has

not been assigned, the hospital shall enter all zeros. In the event the patient is a foreign national who does not have a United States social security number, the hospital shall enter all nines. In the event the patient reports they are a United States citizen, but the social security number is unavailable, enter all eights.

(4) Source of Payment Code - This data element shall be reported at Record 30, Field 04, Beginning Position 25 as an alphanumeric value. Acceptable codes are:
_ = Charity/Self pay
_ = Workmen's Compensation
_ = Medicare
_ = Medicaid
_ = Other Federal Programs (includes Veterans Administration)
_ = Commercial
_ = Blue Cross
_ = Champus
_ = Other
_ = State or Local Government Programs
_ = Other Self-Pay
_ = Commercial PPO
_ = Medicare Managed Care
_ = Medicaid Managed Care
_ = Self-Insured
_ = Commercial HMO

(5) Submission Purpose Code - This data element shall be reported at Record 01, Field 20.8, Beginning Position 183 As a alphanumeric value. Acceptable codes are C = Claim, D = Discharge Statement, and B = Both. This code is required if the a hospital bill clearinghouse is utilized in the data collection effort.

(d) Data may be numeric or alphanumeric. All numeric data shall be right justified and zero-filled. All alphanumeric data shall be left justified. The length of all records is 192 characters. Conditional data fields shall be filled with spaces when other data is not present.

(e) Hospitals shall submit the required minimum data set for all patients for which a discharge file is required by this title. For patients with any form of insurance, hospitals shall submit to the council all data elements submitted to any third party payor in addition to data elements in the required minimum data set. The required minimum data set includes the following data elements:

(1) Patient race;

(2) Patient ethnicity;

(3) Patient social security number;

(4) Patient control number;

(5) Patient last name;

(6) Patient first name;

(7) Patient middle initial ;

(8) Patient sex;

(9) Patient birth date;

(10) Type of admission;

(11) Source of admission;

(12) Patient address;

(13) Patient city;

(14) Patient state;

(15) Patient zip;

(16) Admission/start of care date;

(17) Statement covers period from;

(18) Statement covers period through;

(19) Patient status;

(20) Medical record number;

(21) Source of payment code;

(22) Type of bill;

(23) Accommodations revenue codes (all applicable);

(24) Accommodations rates (all applicable);

(25) Accommodation days (all applicable);

(26) Accommodation total charges (all applicable);

(27) Inpatient ancillary revenue code (all applicable);

(28) Units of service (all applicable);

(29) Ancillary charges total (all applicable);

(30) Principal diagnosis code;

(31) Other diagnosis codes (all applicable);

(32) Principal surgical procedure code;

(33) Principal surgical procedure date;

(34) Other surgical procedure codes (all applicable);

(35) Other surgical procedure dates (all applicable);

(36) Admitting diagnosis;

(37) External cause of injury (if applicable);

(38) Procedure coding method used;

(39) Attending physician number;

(40) Operating or other physician number (if applicable);

(41) Other physician number (all applicable);

(42) Attending physician name;

(43) Operating or other physician name (if applicable);

(44) Other physician name (all applicable).

(f) The other provisions of this title not withstanding, hospitals shall not be required to collect or submit data on the race or ethnicity of inpatients for discharges before January 1, 1998.

(g) A submission will consist of a set of the following types of records from the HCFA 1450 specification.

(1) Processor Label Data (Record 01). Files will be formatted so that this is a data record, not a conventional label. From a system standpoint, this will be a 'labelless' file. This record will be the first record in the file.

(2) Provider Data (Record 10). The provider's batch record describes the types of claims submitted for a specific provider. Field 02 of this record identifies the specific type of claim. A provider may be authorized to submit more than one claim type. In that case,

more than one batch will be required to identify each claim type. Each claim in the batch will be edited for claim type. Record 40, Field 04 identifies claim type and will be matched to the batch record for claim type. Each batch record must be followed by claim records and then Provider Batch Control Record (Record 95). This record is required at the beginning of each batch.

(3) Patient Data (Record 20). The patient record is the first record of a claim. It is required for all claim types as it contains the patient's demographic data.

(4) Third Party Payor Data (Record 30). The third party payor record identifies the insurance information for each payor. If the patient has other insurance, two or more records must be submitted, one for each carrier. If the patient has no third party payor, submit one Record 30 with Field 04 = A. NOTE: Records must be in the correct payor priority sequence. The '01' Record determines which source payment code will be considered as primary.

(5) Claim Data (Record 40). The claim data record identifies miscellaneous data needed to process a claim.

(6) Claim Data Conditions and Values (Record 41). This record is used to report condition and value codes. If none are needed, this record is not necessary.

(7) Inpatient Accommodations (Record 50). This record identifies the room charges (revenue codes 100-219) for an inpatient claim.

(8) Inpatient Ancillary Services (Record 60). This record identifies the inpatient ancillary services (revenue codes 220-999). Revenue code '001' (total) is required for all lines of business. It must be the last revenue code listed and must contain the correct totals.

(9) Medical Data (Record 70). This record identifies the diagnosis and surgical procedure code requirements.

(10) Physician Data (Record 80). This record is for the physician license number and name.

(11) Discharge Totals (Record 90). This record is the final record for each discharge and is required for all discharge types. The record count and charges associated with the discharges will be edited to this record. The discharge will be rejected when the counts or totals do not agree to those accumulated while processing the individual records of each discharge. If a record is not submitted for a discharge, enter '0' for that record count.

(12) Provider Batch Control (Record 95). The provider's batch control record contains information for all the claims of a specific claim type. The system will accumulate totals as it processes each claim. The totals are then edited to the batch totals record. When the totals are out of balance, the batch will be rejected.

(13) File Control Totals (Record 99). The processor's file control record contains control information for all the claims in the file.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701436
Jim Loyd
Director of Program Planning
Texas Health care Information Council
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For further information, please call: (512) 424–6492

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TITLE 28. INSURANCE

Part II. Texas Workers' Compensation Commission

Chapter 134. Guidelines for Medical Services, Charges, and Payments

Subchapter E. Health Facility Fees

The Texas Workers' Compensation Commission (the Commission or TWCC) proposes new §134.401, concerning guidelines for acute care inpatient hospital fees and the simultaneous repeal of existing §134.400, concerning the same subject.

The proposed new rule will establish presumptively fair and reasonable payments for acute care inpatient hospital services provided after the effective date of the rule to workers' compensation claimants who were injured on or after January 1, 1991. Subsection (a) of the rule sets out the services to which the rule applies. Subsection (b) contains applicable definitions and general information related to billing for acute care inpatient hospital services. Subsection (c) sets out reimbursement amounts and methods, including reimbursement calculation examples, diagnoses and items which are carved out of the per diem reimbursement, stop-loss reimbursement method, and reimbursement for professional and pharmacy services. This order includes the preamble, which in turn includes the rule.

In formulating the Acute Care Inpatient Hospital Fee Guideline (ACIHFG), the Commission carefully and fully analyzed all of the statutory and policy standards and objectives and all the facts and evidence available. The Commission utilized all of this, and its expertise and experience, to formulate the hospital fee guideline which balances the statutory standards to ensure injured workers receive the quality health care reasonably required by the nature of their injury as and when needed and to ensure the fee guidelines are fair and reasonable, with the statutory objective to achieve effective medical cost control. The Commission obtained, analyzed and used data relevant to ensuring that the fee paid for a workers' compensation patient would not be in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or someone acting on that individual's behalf, and also took into consideration increased security of payment under the Texas Workers' Compensation Act (Act).

It is important that a guideline for acute care inpatient hospital services be adopted so the statutory standards discussed at the beginning of and throughout this preamble are complied with and it is of particular importance because the challenge of the validity of the current ACIHFG continues in the courts. In the event the current ACIHFG is ruled invalid, inaction in the adoption of this new ACIHFG would leave the initial determination of what is a fair and reasonable rate for inpatient

hospital services to workers' compensation participants. Such a situation would be expected to increase the number of disputes regarding hospital fees and increase costs to the system participants and to the Commission. The fee guideline also should be adopted because of the facts discussed in this preamble which support the Commission's conclusion that the existing fee guideline rates should be revised.

Beginning in early 1996, the TWCC Medical Advisory Committee (MAC) provided input regarding revision of the current ACIHFG. In April of 1996 the MAC recommended to the Commission the proposal of the ACIHFG as eventually published in the July 26, 1996 *Texas Register* (21 TexReg 6939). This July 26 proposal was modified pursuant to information obtained from the TWCC Medical Advisory Committee, a Commission-appointed ACIHFG Task Force, and numerous public comments. In developing the rule proposal published here, the Commission utilized the information gathered during the development of the July 26, 1996 proposal and the information gathered following that proposal.

Following a public hearing on the proposed rule as published in the July 26, 1996 *Texas Register* (which was held on September 12, 1996), the Chairman of the Commission appointed an ACIHFG Task Force (the Task Force) as authorized by the Act, §413.006 composed of hospital, business, and employer representatives. The Task Force met on six occasions to exchange information and discuss the issues. The Commission staff took the ideas and information provided by the Task Force into consideration in developing this proposed new rule.

Public comment on the ACIHFG proposed in the July 26, 1996 issue of the *Texas Register* raised many issues including the carve out or exclusion of certain items and services from the guideline, changes in the stop-loss threshold, exemption of small/rural hospitals from the guideline, inclusion of outpatient services in the guideline, tiering of the surgical reimbursement rates, regional variation in reimbursement rates, and the effect of inflation on hospital reimbursement. Some Commenters also questioned the validity of using managed care contracts as a basis for workers' compensation reimbursements, raising issues such as differences in case mix, differences in case complexity, and use of steerage in managed care contracts.

As a result of analysis of the information obtained by the Commission from these various sources and additional information gathered by the Commission staff, changes were made to the rule as proposed in the July 26, 1996 *Texas Register*. The knowledge which has been accumulated by the Commission since the July 26, 1996 proposal of an ACIHFG was used in formulating the current proposal.

This proposed new rule will fulfill the requirements of the Texas Labor Code, §413.011 that the Commission by rule establish medical policies and guidelines, and the Texas Labor Code, §413.012 that the Commission periodically review and revise its fee guidelines. The new rule will revise provisions in the current guideline including: increasing the per diem reimbursement for hospital services related to a medical admission from $600 to $870; decreasing the per diem reimbursement for services related to a surgical admission from $1,100 to $1,045; decreasing the per diem reimbursement for intensive or cardiac care units services from $1,600 to $1,560; redefining the exemption for "small/rural" hospitals as an exemption for "hospitals with 100 or less licensed beds"; revising the basic reimbursement method to require the payment of the lesser of billed charges, contract rates or the per diem in the guideline; exempting from the per diem reimbursement provisions of the guideline certain high-cost services, supplies, and diagnoses in addition to MRIs, CAT scans and implantables; eliminating the requirement that an invoice be submitted for reimbursement of implantables; and lowering the stop-loss threshold to $40,000 and the stop-loss reimbursement factor to 75%.

The Commission considered all relevant statutory and policy standards and objectives and designed this proposed rule to achieve those standards and objectives, including the following:

(1) establish guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services;

(2) ensure that injured workers receive the health care reasonably required by the nature of their injury, as and when needed;

(3) ensure guidelines for medical services fees are fair and reasonable;

(4) design fee guidelines to ensure quality health care to the injured workers of Texas;

(5) design fee guidelines to achieve effective medical cost control;

(6) ensure guidelines for medical services fees do not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or someone acting on that individual's behalf;

(7) consider the increased security of payment afforded by the Act in establishing the fee guidelines;

(8) maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the Commission in adopting medical fee guidelines;

(9) ensure the Commission's database contains information necessary to detect practices and patterns in medical charges and actual payments; and

(10) ensure the Commission's database can be used in a meaningful way to allow the Commission to control medical costs as provided by the Act.

This proposed new rule achieves these objectives by its provisions, including but not limited to the following:

(1) specifying the fees to be paid for acute care inpatient hospital services provided under the Texas Workers' Compensation Act;

(2) considering the amounts currently accepted by hospitals as payment in full under contracts for acute care inpatient services and for Medicare patients when setting the per diem rates, to avoid any adverse effect on the access to or quality of medical care, to ensure the per diem rates are fair and reasonable, to achieve effective medical cost control, and to ensure workers' compensation rate is not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living;

(3) requiring that payment to a hospital be the lesser of the amount specified in the fee guideline, the amount specified in a prenegotiated contract with the carrier, or billed charges to ensure that hospitals are not reimbursed for workers' compensation patients in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living, and to achieve effective medical cost control;

(4) including non-workers' compensation data in the data reviewed and utilized by the Commission to allow the Commission to detect practices and patterns in medical charges and actual payments,to determine fair and reasonable rates, to ensure access to quality medical care, to ensure that hospitals are not reimbursed for workers' compensation patients in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living, and to achieve effective cost control;

(5) considering the security of payment in the workers' compensation system resulting from the absence of co- payments and deductibles which are included in some managed care contracts, when setting rates and ensuring fees that are not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living;

(6) providing for reimbursement to acute care hospitals which is sufficient to induce a sufficient number of hospitals to continue in the system to ensure access to quality medical care for injured workers in Texas; and

(7) exempting hospitals with 100 or less licensed beds, lowering the stop-loss threshold, and including substantial carve outs from the per diem fees to ensure that reimbursement to hospitals is fair and reasonable and is sufficient to avoid any adverse effect on the access to or quality of medical care.

These statutory and policy standards require the Commission to establish guidelines which balance the various interests in the workers' compensation system by ensuring that medical services fees are fair and reasonable, that injured workers receive quality health care, and that effective medical cost control is achieved. In addition to balancing these interests, and considering the increased security of payment in workers' compensation, the Texas Labor Code in §413.011 requires that the Commission ensure guidelines for medical services fees do not provide for payment in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or someone acting on that individual's behalf. To comply with this statutory standard, the Commission, in reviewing and revising rule 134.400, sought to analyze the hospital reimbursements contained in that rule in relation to reimbursements hospitals were accepting from Medicare and under contracts as payment in full for persons of an equivalent standard of living outside the workers' compensation system for treatment similar to that provided to injured workers.

The Commission reviewed and analyzed a tremendous amount of data in determining the reimbursement rate set by this proposed rule for acute care inpatient hospital services, including the Commission's database of electronically filed bills and payments, 2564 managed care contracts or summaries of managed care contracts (from the hospitals receiving approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 for acute care hospital inpatient services), analysis of Medicare rates, and state and federal agency information related to hospital health care. Contracts have been obtained from some of these same hospitals for the period October 1995 through October 1996.

Texas acute care hospitals in 1995 received 33.3% of their gross patient revenue from third party payors and 40% from Medicare. Because these sources account for the vast majority of hospital patient revenue, the reimbursements paid by these payors is relevant to determining what fees are paid for similar treatment of persons of an equivalent standard of living, for establishing fair and reasonable fees, and for establishing fees at which hospitals will continue to provide quality health care while the Commission still achieves cost control. Voluntary participation in managed care contracts and in Medicare shows that reimbursements received from those payors are sufficient to cover the hospitals' costs.

Per diem fees is the most commonly used (51.5%) method in the managed care contracts, is the method used in the 1992 ACIHFG, and is administratively convenient. The managed care per diem contracts set separate rates for medical services, surgical services, and intensive care unit services or for combined medical/surgical. The per diem managed care contracts do not break the fees down into smaller segments of treatments and services, or into a larger number of categories. Rather, the one inclusive fee for each of the medical, surgical, and ICU categories of service in the managed care contracts shows that it is appropriate to have one fee for medical, one fee for surgical, and one fee for ICU/CCU. The more recent managed care contracts reviewed by the Commission indicate that use of per diem rates is increasing in the industry. This shows that per diem rates established for what may be a broad category of services do result in fair and reasonable rates without different fees for smaller categories of services.

The per diem amounts proposed in this rule for medical ($870), surgical ($1045), and ICU/CCU ($1560) services are the average of the per diem managed care contracts for each category. Other provisions in the proposed rule serve to increase actual reimbursement, so this rule actually reimburses in excess of the contract averages. (See relevant discussions elsewhere in this preamble, including discussions regarding the 100 bed exemption, stop loss, and carve outs. Alternate methods of reimbursement were considered by the Commission and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges, or are difficult to use because of the limited diagnosis groups applicable to workers' compensation cases.

All carved out items and services that are in any of the managed care contracts (even those in less than 1%) and are applicable to typical workers' compensation case are included as carve outs in this rule and increase reimbursement. Reimbursement methods for the carve-outs are based on the managed care contracts. Other provisions which serve to increase reimbursement include a stop loss provision, the threshold for which and the percentage reimbursement for which was determined from the managed care contracts.

The proposed rule exempts hospitals with 100 beds or less; the Commission has no data at this time to determine fair and reasonable fees for small hospitals or to distinguish between rural and non-rural hospitals. The Commission will be reviewing the issue of small hospital exemption to determine if there is available relevant reliable data that it can obtain and analyze. The exemption for hospitals with 100 or fewer licensed beds may be deleted in its entirety, or may be deleted only for rural or only for non-rural hospitals. In addition, the Commission may receive or obtain information or data sufficient to establish a rate for hospitals with 100 or less licensed beds that may be the same as, or may differ from the rate established for other hospitals. Hospitals with 100 or less licensed beds are therefore encouraged to comment on the provisions of this rule proposal.

Critics of using managed care contracts as a basis for workers' compensation reimbursements allege that payments for workers' compensation patients should be higher than managed care rates because of differences in case complexity, case mix and length of stay. The managed care rates are appropriate and do not need to be adjusted upward for workers' compensation cases. An actuarial study using two methods, including one that adjusted for typical length of stay, shows that workers' compensation cases are not more complex than managed care cases. Commission data shows that over 80% of possible emergency room admissions will be reimbursed at a fair and reasonable rate rather than the per diem rate, because of the carve outs in the rule. If any additional reimbursement is appropriate for any of the alleged reasons, the extensive carve outs and other items of the rule that increase reimbursement would compensate. Information received from the Texas Hospital Association in response to the Commission's 1994 Request for Information stated that it was unaware of any adverse impact on access to care as a result of the 1992 per diem rates, and the Commission has no knowledge or evidence which would indicate that a hospital(s) has refused to treat workers' compensation patients because of the fees provided in the 1992 ACIHFG. Therefore, there should be no decrease in access to care for injured workers under this proposed new rule. The per diem fees proposed in this rule are higher than the workers' compensation reimbursements voluntarily contracted for by the hospitals which contracted for workers' compensation in their managed care contracts, and other provisions of the rule serve to increase reimbursement above the amount stated as the per diem rate.

Because very few of the managed care contracts contain steerage guarantees or exclusivity clauses, and because of statutory standards, these issues were not addressed in this proposed rule. Additionally, workersþ compensation does not rely on co-payments or deductibles which are key components in managed care. The absence of the necessity to collect such co-payments or deductibles increases the security of payments in the workersþ compensation system which would argue for setting workers' compensation rates lower than managed care rates. The Commission has, however, chosen not to do so because the quantifiable effect of the security of payment on rates is unclear.

The Commission cannot at this time confirm or dispute the contention that the costs of outpatient services are different when provided in a hospital. Because reimbursement for typical outpatient services at the TWCC Medical Fee Guideline rates could affect access to services and quality of care for injured workers, outpatient services will be reimbursed at fair and reasonable rates for these hospitals. This will ensure access to quality health care for injured workers by ensuring that hospitals will continue to provide outpatient services to workers' compensation patients. Outpatient emergency services are not subject to this guideline. However, emergency room services associated with a hospital admission are subject to the guideline. Emergency transportation, other than air ambulance, will continue to be reimbursed in accordance with the TWCC Medical Fee Guideline in effect at the time the services are rendered.

Tiered surgical rates are not necessary for a rate to be fair and reasonable, or to ensure access to quality health care. Tiering of per diem rates was not the predominant method of utilizing per diem reimbursements; only 7% of the managed care per diem contracts contained some form of tiered per diem for surgical admissions. Therefore, consideration of front loaded expense and severity must have been factors in negotiating the contract rates; to the extent they were not, other provisions in this proposed rule will compensate, as they serve to increase actual reimbursement.

Regional rate variation is not necessary for a rate to be fair and reasonable, or to ensure access to quality health care. There is no correlation, and in some regions a negative correlation, between the areas with higher labor costs and those with the higher per diem contract rates. Analysis of hospitals within the same chain of hospitals reveals no consistency by hospital, by metropolitan statistical area (MSA), or by company. There is also no correlation between hospital type or hospital bed size. Differences which may be attributable to hospital size have been recognized and accounted for by the exemption for hospitals with 100 or less licensed beds. Differences in levels of care provided by some hospitals have been recognized and accounted for by the carve outs.

An inflation adjustment is not necessary to ensure fair and reasonable rates or to ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients. A rise in the Medical Care Services (MCS) CPI does not necessarily indicate that hospitals should receive greater reimbursements and the Commission did not directly use it to determine hospital reimbursement rates. However, when compared to inflation, the fees in this rule are sufficient to account for the inflation of 12% reflected in the CPI for the period from 1993 to 1996, and the estimated 14.3% increase over current rates (which percentage does not account for any possible increased reimbursement due to the 100-bed exemption) is just under the MCS CPI of 18% for the period 1993 to 1996.

Preliminary analysis of the contracts for the period October 1995 through October 1996 shows little or no change in the average per diem reimbursement rates and shows that the total number of contracts that have per diem rates is increasing. 52.6% of the hospitals have more per diem contracts than before and 94.8% of the per diem rates for the same hospital were either reduced, stayed the same, or increased by less than 10%. Action by the federal advisory panel on Medicare, and a report on hospital

performance for the past five years reinforce the Commission's conclusion regarding adjustments for inflation.

The Commission also compared the per diem rates derived from the managed care contracts to Medicare rates. Studies show that Medicare patients are of an equivalent standard of living to workers' compensation patients. An actuarial study, adjusted for length of stay, calculated the estimated Medicare per diem rates for the 5 DRG's that would account for 60% of workers' compensation inpatient hospital payments if a DRG system were in place. The study concludes that for these 5 DRG's, hospitals will receive higher reimbursement for workers' compensation patients than they do for Medicare patients. This reinforces the Commission's conclusion that the per diem rates from the managed care contracts are fair and reasonable, will ensure access to quality medical care, will achieve effective cost control, and will not pay in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living.

Some comparisons between managed care and workers' compensation may support an argument that the workers' compensation rate should be a reduction from the managed care rates. Comparisons consider the fact that workers' compensation cases are less complex than managed care cases, the inclusion of carve outs in this rule that are carved out in very few of the managed care contracts, the fact that the carve outs and the stop loss may to some extent address the same high cost cases and thus overlap, the lowering of the stop loss threshold even though hospital charges have been inflated, the 100-bed exemption, and increased security of payment in workers' compensation. The Commission believes that these are all factors that should be watched and analyzed as experience with any new rule is gained. Data, information, and input will be obtained and reviewed, and action taken to adjust the fees and other aspects of the rule as appropriate.

The Commission is faced with the difficult task of meeting numerous, often seemingly contradictory, statutory standards and criteria. The legislature called for the Commission to balance the statutory standards and the interests of all those affected. This necessarily involves the exercise of the Commission's discretion and judgment which rests in part on the agency's experience and expertise. After thorough analysis of alternatives and available data, the Commission determined what data would be relevant and how to secure reliable data, secured that data, analyzed the data, examined it again to determine if it was indeed reliable and relevant, received and analyzed all input from affected persons, and considered alternatives. The result of the Commission's full and objective analysis is the rule proposed by this Commission order. As described and explained in more detail throughout this preamble, based upon a review of the applicable factual, legal, and policy concerns, the Commission concludes that this proposed rule meets all statutory standards and criteria and is the appropriate and rational response to those standards and criteria and to the facts before the Commission.

In developing this proposed new rule, the Commission utilized its database of workers' compensation hospital charges and payments. This database contains reliable information submitted electronically by hospitals on UB92 reporting forms. Information from this database for the period October 1, 1994 through June 30, 1996 was used. This data represents over 12,000 hospital bills and in excess of 153 million dollars in hospital charges. This Commission data was useful in determining the average length of stay for hospitalized workers' compensation patients, types of cases which utilize hospital services in the workers' compensation system, the amount of reimbursement hospitals receive under the workers' compensation system and substantial and non-uniform differences between hospital charges and what is being accepted by hospitals as payment for the same or similar services. Although this Commission data was useful in these respects, it was determined that additional data would be useful in determining fair and reasonable reimbursements for acute care inpatient hospital services in workers' compensation, ensuring access to quality health care, and in obtaining information relevant to effective cost control and to the statutory prohibition of fees in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living. The consideration and analysis of these statutory factors with regard to various types of data, is described later in this preamble.

The hospital charge data in the Commission's database, as with all hospital charge data, shows that it is well above the actual fees paid for most hospital services. A study by Commission staff indicated that charges for surgical hospital admissions (as reported by the Texas Department of Health) increased by 107% from 1992 through 1996 and by 65% from 1993 through 1996, whereas for those same periods of time the Consumer Price Index (CPI) reflected an inflation rate of 16% and 12% respectively, and the Medical Care Services group of the CPI reflected an inflation rate of 29% and 18% respectively. For these reasons, hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors. The hospital payment data contained in the Commission's database, for the most part, simply reflects the reimbursement schedule contained in current rule §134.400 and does not provide information regarding the current payments accepted in the largest segments of the marketplace for hospital services.

An additional source of information on hospitals was the Texas Department of Health, Bureau of State Health Data and Policy Analysis Annual Survey of Hospitals which provides aggregate financial information, utilization and other data from all licensed hospitals in Texas. This information was useful in determining the bed-size of hospitals in Texas and revenue sources of Texas hospitals e.g. medicare, managed care.

In order to determine what reimbursements were being paid to hospitals outside the workers' compensation system, the Commission sought a source of accurate, verifiable data. The Texas Department of Health, Bureau of State Health Data and Policy Analysis' 1996 report from its annual survey of hospitals, revealed that in 1995 Texas acute care hospitals received 40% of their gross patient revenue from Medicare, and 33.3% from third party payors. Because these sources account for the vast majority of hospital patient revenue, the reimbursements paid by these payors is a relevant basis for comparison between workers' compensation reimbursements and these other major reimbursement systems for similar hospital services for persons of an equivalent standard of living, and for establishing fair and reasonable fees for workers'

compensation. The fact that hospitals on average receive over 70% of their gross patient revenue from choosing to participate in Medicare and managed care, indicates that reimbursements received from those payors are sufficient to cover the hospitals' costs. Workers' compensation inpatient hospital payments constitute less than 1% of total inpatient hospital business. (See also, relevant discussions regarding managed care contract data, Medicare rates comparison, case complexity, and data used in studies performed by Milliman and Robertson.)

Texas Labor Code §413.011, which provides that the Commission establish fee guidelines, specifies that those guidelines may not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. To comply with this legislative standard, the Commission reviewed the payments made for health care services outside the workers' compensation system. The managed care contracts are directly relevant to the hospital fee guideline rulemaking proceeding.

Managed care contracts are relevant to what fair and reasonable reimbursement (§413.011(b)) is - they are a market price negotiated voluntarily. They show rates a business (a hospital) which voluntarily accepts patients is willing to accept for provision of services.

Managed care contracts are relevant to achieving cost control (§413.011(b)) because they are the lowest rates negotiated for the working age population, which is also the population of workers' compensation injured workers.

Managed care contracts are relevant to ensuring access to quality care (§413.011(b)), because as voluntarily negotiated rates, they reflect rates at which a hospital will continue to take patients.

Managed care contracts are relevant to the statewide database (§413.007) the Commission is required to maintain: a database of charges, actual payments, and treatment protocols that is sufficient to detect practices and patterns in charges and payments and can be used in a meaningful way to control costs.

The managed care contract information is highly reliable; it was obtained directly from the hospitals. Either copies of the actual contracts were provided or certified summaries of information from the contracts was provided by the hospitals.

To gather data regarding the amounts being accepted from third party payors as payment in full for acute care inpatient hospital services in Texas, the Commission ordered and obtained from hospitals copies of contracts or summaries of contracts reflecting rates accepted by selected Texas hospitals as payment in full from third party payors, including managed care organizations, for inpatient hospital services, both workers' compensation and non-workers' compensation.

To determine which hospitals would be required to provide contract information, the Commission's database was used to rank hospitals by the dollar amount of reimbursement each hospital received for workers' compensation cases for calendar year 1994. The year 1994 was chosen because it was the most recent full year of data available at the time the ranking was done. After ranking the hospitals, it was determined that the top 80 hospitals received approximately 80% of the total workers' compensation reimbursement paid to hospitals in 1994 for acute care hospital inpatient services. None of the hospitals which received the remaining 20% of the total 1994 hospital reimbursement for acute care inpatient services were reimbursed a significant portion of the total workers' compensation reimbursement for such services. As a result, the Commission determined that obtaining contracts from the top 80 hospitals would provide relevant information to determine fair and reasonable rates, access to quality health care, cost control, and payments for similar treatments of persons of an equivalent standard of living.

The Commission sent letters to these 80 hospitals requesting copies of all contracts or other agreements reflecting rates accepted as payment in full by each hospital that were in effect for any dates of services on or after January 1, 1994 through October 1, 1995. Almost all of the hospitals refused to voluntarily produce the contracts and, as a result, the Commission issued orders on January 26, 1996 requiring the production of the contracts. The Texas Hospital Association, as well as almost all of the hospitals from whom contracts were sought filed suit. The parties reached an agreement for issuance of a permanent protective order which prohibits the Commission from disclosing these contracts and summaries and certain information in those contracts and summaries (generally described as certain hospital identifying information related to those contracts and summaries).

Because of mergers, acquisitions, corporate buyouts and other similar ownership changes, all of the 80 hospitals originally identified did not individually respond to the Commission orders. However, none of the hospitals ordered to produce contracts reported that they had no such contracts. The hospitals producing contracts were located throughout the state. With the exception of one, all of the following hospitals producing contracts are 100 or more licensed beds in size, ranging in size from less than 200 beds to over 900 beds.

TOP 80 HOSPITALS (Calendar Year 1994, Sorted Alphabetically):

All Saints Episcopal Hospital, Fort Worth

AMI Twelve Oaks Hospital, Houston

AMI Park Plaza Hospital, Houston

Arlington Memorial Hospital, Arlington

Baptist Memorial Hospital System, San Antonio

Baptist Hospital of Southeast Texas, Beaumont

Baylor University Medical Center, Dallas

Bethania Regional Health Care Center, Wichita Falls

Bexar County Hospital District, San Antonio

Brackenridge Hospital, Austin

Brownsville Medical Center, Brownsville

Citizens Medical Center, Victoria

Cypress Fairbanks Medical Center Hospital, Houston

Doctors Hospital East Loop, Houston

Garland Community Hospital, Garland

Good Shepard Medical Center, Longview
Harris Methodist-Fort Worth, Fort Worth
Harris Methodist H E B, Bedford
HCA Medical Center Hospital, Houston
HCA Medical Plaza Hospital, Ft Worth
HCA North Hills Medical Center, North Richland Hills
HCA West Houston Medical Center, Houston
HCA Medical Center-Plano, Plano
HCX South Arlington Medical Center, Arlington
Hendrick Medical Center, Abilene
Hermann Hospital, Houston
High Plains Baptist Hospital, Amarillo
Hillcrest Baptist Medical Center, Waco
Houston NW Medical Center, Houston
Humana Hospital-Clear Lake, Webster
Humana Hospital Metro, San Antonio
Humana Hospital-San Antonio, San Antonio
Humana Hospital Medical City-Dallas, Dallas
McAllen Medical Center, Mc Allen
Medical Arts Hospital, Dallas
Medical Center Hospital, Tyler
Medical Center Hospital, Odessa
Memorial City Medical Center, Houston
Memorial Medical Center, Corpus Christi
Memorial Hospital System, Houston
Methodist Hospital Lubbock, Lubbock
Methodist Medical Center, Dallas
Midland Memorial Hospital, Midland
Mother Frances Hospital Regional Healthcare Center, Tyler
Nix Medical Center, San Antonio
Northeast Medical Center Hospital, Humble
Northwest Texas Hospital, Amarillo
Osteopathic Medical Center of Texas, Fort Worth
Park Place Hospital, Port Arthur
Parkland Memorial Hospital, Dallas
Presbyterian Hospital, Dallas
Providence Memorial Hospital, El Paso
RHD Memorial Medical Center, Dallas
Rio Grande Regional Hospital, Mc Allen
Rosewood Medical Center, Houston
Santa Rosa Hospital, San Antonio
Scott and White Memorial Hospital, Temple
Seton Medical Center, Austin
Shannon West Texas Memorial Hospital, San Angelo
Sierra Medical Center, El Paso
Southwest Texas Methodist Hospital, San Antonio
Spohn Hospital, Corpus Christi
St. Joseph Hospital of Houston, Houston
St. Lukes Episcopal Hospital, Houston
St. Davids Community Hospital, Austin
St. Joseph Hospital, Fort Worth
St. Elizabeth Hospital, Beaumont
St. Anthonys Hospital, Amarillo
St. Mary of the Plains Hospital, Lubbock
St. Paul Medical Center, Dallas
St. Lukes Lutheran Hospital, San Antonio
Sun Belt Regional Medical Center, Houston
Sun Towers Hospital, El Paso
The Methodist Hospital, Houston
University Medical Center, Lubbock
University of Texas-Medical Center, Galveston
Valley Baptist Medical Center, Harlingen
Vista Hills Medical Center, El Paso
Westbury Hospital, Houston
Zale Lipshy University Hospital, Dallas

Two of these hospitals had closed and did not submit contracts or summaries of contract information. A total of 2564 contracts or summaries of contracts were received. Of these, 1320 were actual contract documents and 1244 were detailed summaries, prepared by the hospitals, of information from contracts.

For the calendar year 1995 the Commission has identified Texas hospitals which received approximately 80% of the total workers' compensation reimbursement paid to hospitals in that year for acute care inpatient hospital services. The Commission on November 13, 1996, sent letters to these hospitals requesting copies of all their contracts or other agreements (or certified summaries) reflecting rates accepted as payment in full for acute care inpatient hospital services, that were in effect for any dates of services on or after October 2, 1995 through October 1, 1996. In addition, the Commission requested copies of contracts from hospitals which were on the list of top 80 hospitals for the calendar year 1994 but were not on the list for 1995. The Commission has performed some preliminary analysis of these contracts, and will continue to analyze them as they are received.

HOSPITALS RECEIVING TOP 80% OF TOTAL REIMBURSEMENT FOR WORKERS' COMPENSATION ACUTE INPATIENT HOSPITAL CARE (Calendar Year 1995, Sorted Alphabetically):

All Saints Episcopal Hospital, Fort Worth
Brownsville Medical Center, Brownsville
Park Plaza Hospital, Houston
Twelve Oaks Hospital, Houston
Arlington Memorial Hospital, Arlington
Baptist Health Care System, Beaumont
Baptist Memorial Hospital System, San Antonio
Baylor University Medical Center, Dallas
Bethania Regional Health Care Center, Wichita Falls
Brackenridge Hospital, Austin
Citizens Medical Center, Victoria
Clear Lake Regional Medical Center, Webster
Columbia Medical Center East, El Paso
Columbia Medical Center West, El Paso
Cypress Fairbanks Medical Center Hospital, Houston
Doctors Hospital East Loop, Houston
East TX Medical Center, Tyler
Garland Community Hospital, Garland
Good Shepherd Medical Center, Longview
Harris Methodist H E B, Bedford
Harris Methodist-Fort Worth, Fort Worth
HCA Arlington Medical Center, Arlington
HCA North Hills Medical Center, North Richland Hills
Hendrick Medical Center, Abilene
Hermann Hospital, Houston
High Plains Baptist Hospital, Amarillo
Hillcrest Baptist Medical Center, Waco
Houston NW Medical Center, West Houston
McAllen Medical Center, McAllen
Medical Arts Hospital, Dallas
Medical Center of Plano, Plano
Medical Center Hospital, Odessa
Medical City-Dallas Hospital, Dallas
Memorial Hospital & Medical Center, Midland
Memorial Hospital Memorial City, Houston
Memorial Health Care, Houston
Memorial Medical Center, Corpus Christi
Methodist Hospital Lubbock, Lubbock
Methodist Medical Center, Dallas
Metropolitan Hospital, San Antonio
Mother Frances Hospital Regional Healthcare Center, Tyler
Nix Medical Center, San Antonio
Northeast Medical Center Hospital, Humble
Northwest TX Health Care System, Amarillo
Osteopathic Medical Center of TX, Fort Worth
Park Place Hospital, Port Arthur
Parkland Memorial Hospital, Dallas
Plaza Medical Center, Fort Worth
Presbyterian Hospital, Dallas
Providence Memorial Hospital, El Paso
RHD Memorial Medical Center, Dallas
Rio Grande Regional Hospital, McAllen
Rosewood Medical Center, Houston
San Antonio Regional Hospital, San Antonio
Santa Rosa Health Care Corporation, San Antonio
Scott and White Memorial Hospital, Temple
Seton Medical Center, Austin
Shannon Medical Center, San Angelo
Sierra Medical Center, El Paso
Southwest TX Methodist Hospital, San Antonio
Spohn Health System, Corpus Christi
St. Anthonys Hospital, Amarillo
St. Davids Community Hospital, Austin
St. Elizabeth Hospital, Beaumont
St. Joseph Hospital of Houston, Houston
St. Lukes Baptist Hospital, San Antonio
St. Lukes Episcopal Hospital, Houston
St. Mary of the Plains Hospital & Rehab Center, Lubbock
St. Paul Medical Center, Dallas
Sun Belt Regional Medical Center, Houston
The Methodist Hospital, Houston
University Health Care System, San Antonio
University Medical Center, Lubbock
University of TX-Medical Branch, Galveston
Valley Baptist Medical Center, Harlingen
West Houston Medical Center, Houston
Zale Lipshy University Hospital, Dallas

HOSPITALS WHICH WERE INCLUDED IN THE TOP 80 HOSPITALS FOR CALENDAR YEAR 1994, BUT NOT INCLUDED IN TOP 80% FOR CALENDAR YEAR 1995 (Sorted Alphabetically):

Presbyterian Hospital of Plano, Plano
HEALTHSOUTH Medical Center, Dallas

Texas Orthopedic Hospital, Houston

Columbia Bay Area Medical Center, Corpus Christi

Providence Health Center, Houston

Ben Taub General Hospital, Waco

Health South Rehab Institute of San Antonio, San Antonio

R.E. Thomason General Hospital, El Paso

San Jacinto Methodist Hospital, Baytown

John Peter Smith Hospital, Fort Worth

Doctors Regional Medical Center, Corpus Christi

Wadley Regional Medical Center, Texarkana

St Joseph Regional Medical Center, Bryan

Mercy Regional Medical Center, Laredo

Bayshore Medical Center, Pasadeno

St. Davids Rehab Center, Austin

Wichita General Hospital, Wichita Falls

Victoria Regional Medical Center, Victoria

St. Mary Hospital of Port Arthur, Port Arthur

Spring Branch Medical Center, Houston

Conroe Regional Medical Center, Conroe

In reviewing rule 134.400, the current Acute Care Inpatient Hospital Fee Guideline, the Commission considered alternate methods of reimbursement for acute care inpatient hospital services. Cost-based methods of reimbursement which estimate the cost of treating a case by multiplying the hospital charges by the cost-to-charge ratio (obtained by dividing the hospital's total reported expenses by total reported revenue for the same period) were considered. To determine the reimbursement for a particular service, the billed charge is multiplied by the cost-to-charge ratio for that hospital. This method seeks to produce reimbursements which take into consideration the hospital's cost to deliver the service.

The Commission chose not to propose a cost-based reimbursement methodology. The cost calculation on which cost-based models are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs. This is exemplified by the substantial and non-uniform differences between these charges and what is being accepted by hospitals as payment, and by the 107% increase in surgical hospital admission charges in the same time period in which the CPI inflation rate was 16% and the MCS of the CPI inflation rate was 29%. Therefore, under a so-called cost based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs. In addition, setting individual ratios or negotiating with each hospital would be administratively burdensome for the Commission and for workers' compensation system participants and would require additional Commission resources.

A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Prospective payment methods, in addition to the per diem method ultimately chosen, were considered. Prospective payment amounts can be determined by using diagnostic-related groups (DRGs). This method of reimbursement involves paying the hospital a predetermined fee based upon the patient's diagnosis rather than the length of stay or specific services provided. DRGs are difficult to use in workers' compensation because only about five (5) out of the approximately 494 DRGs used by other payors make up an estimated 60% of inpatient hospital workers' compensation cases. In addition, the Commission lacks the ability to target DRGs within its database because DRG designations are not reported on bills received by the Commission.

After careful analysis of relevance (discussed elsewhere in this preamble) regarding the use of the hospital contracts in determining a guideline for fair and reasonable workers' compensation inpatient hospital reimbursements, the Commission concludes that the hospital contracts provided the most accurate, verifiable information of the current hospital service market and thus the most relevant information regarding fair and reasonable rates, access to quality health care, cost control, and fees paid for similar treatment by persons of an equivalent standard of living. Hospitals are voluntarily participating at these negotiated rates for what constitutes 33.3% of their gross revenue.

The contracts and contract summaries were analyzed by comparing the rates for medical services, surgical services, intensive care unit services, and combined medical/surgical services in each contract. Data on approximately 2564 contracts was received and analyzed. Of these 2564 contracts, approximately 10.8% based fees on diagnostic related groups (DRGs); approximately 30.5% based fees on a discount from charge; approximately 51.5% based fees on a per diem rate; and approximately 7.2% based fees on some other method (such as capitation, case by case, or some combination of methods).

Some contracts included hospital rates for workers' compensation cases and approximately 1.3% of the contracts were for workers' compensation cases only.

The average workers' compensation per diem rate in the hospital contracts was $610 for medical cases, $1030 for surgery cases, and $1514 for ICU cases.

The per diem method was chosen for proposed §134.401 because (as discussed elsewhere in this preamble) the per diem method of reimbursement was the most commonly used (51.5%) method for inpatient hospital reimbursement in the

hospital contracts, because of the disadvantages of other payment methods (described elsewhere in this preamble), because this is the method used in current rule §134.400 for workers' compensation inpatient hospital reimbursement and therefore allows greater continuity in administrative billing procedures, and because the per diem method has advantages in administrative convenience in billing and review of bills.

To arrive at the per diem reimbursement rates for the proposed guideline, the per diem contract amounts for medical, surgical, and ICU/CCU services for non-workers' compensation cases were averaged for each category on a state-wide basis. These averages revealed that the Commission's current per diem reimbursement for acute care inpatient medical services is low ($600) when compared to the state-wide average per diem amount derived from the hospital contracts and summaries ($870). The contract data also revealed that the Commission's current per diem reimbursement for acute care inpatient surgical services ($1,100) is high when compared to the state-wide average per diem amount derived from the hospital contracts and summaries ($1,045). Data analysis showed that the Commission's current per diem reimbursement for intensive care unit services ($1,600) is high when compared to the state-wide average per diem derived from the hospital contracts and summaries ($1,560). The rates in the proposed rule are the average per diem amounts by category derived from the hospital contracts and summaries. Because hospitals have voluntarily contracted at these rates, these rates will provide fair and reasonable rates for workers' compensation, ensure access to quality care while achieving effective cost control and ensure workers' compensation fees are not in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living.

The hospital contracts and summaries were analyzed to determine what types of services and/or supplies were reimbursed outside or in addition to ("carved out of") the per diem rates in the contracts. A listing of the services and supplies carved out of the hospital contracts was compiled and placed in order according to the frequency at which the carve out occurred in the contracts. All carved out items and services that are in any of the managed care contracts (even those in less than 1%) and are applicable to typical workers' compensation cases are included as carve outs in this rule and increase reimbursement. Reimbursement methods for the carve outs are based on the managed care contracts. The carved out services were identified by ICD-9 diagnostic codes and carved out supplies and equipment were identified by revenue codes. The following services and/or supplies are reimbursed in addition to the per diem rates in the proposed new rule: MRI's (revenue codes 610 - 619) and CAT scans (revenue codes 350 - 352, 359); implantables (revenue codes 275, 276, and 278); hyperbaric oxygen (revenue code 413); blood (revenue codes 380 - 399); air ambulance (revenue code 545); and orthotics and prosthetics (revenue code 274). For the following ICD-9 codes, reimbursement for the entire admission shall be at a fair and reasonable rate; trauma (ICD-9 Codes 800.0 - 959.50); burns (ICD-9 Codes 940 - 949.9); and HIV (ICD-9 Codes 042 - 044.9). Pharmaceuticals greater than $250 per dose are reimbursed at cost plus 10% in addition to the per diem rate.

Implantables, orthotics, and prosthetics are proposed to be reimbursed at cost to the hospital plus 10% of the cost to ensure that the cost of the item and related overhead costs are covered by the reimbursement. This method of reimbursement for revenue code carve outs is the predominant method used in the hospital contracts.

In addition to the ICD-9 codes and revenue codes carved out of the proposed ACIHFG, pharmaceuticals with a cost greater than $250 per dose are also carved out of the proposed per diem reimbursements. The threshold of $250 is chosen because it represents the 50th percentile of the array of monetary thresholds used in the hospital contracts. In addition, $250 was the most commonly used threshold amount for pharmaceutical carve outs contained in the hospital contracts. Carved out pharmaceuticals are reimbursed at cost to the hospital plus 10% of the cost to ensure that the cost of the drug and related overhead costs are covered by the reimbursement.

The proposed guideline does not require that an invoice be submitted for reimbursement of implantables, to avoid unnecessary paperwork for hospitals and carriers.

The services and supplies chosen for carve out increase hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by ensuring that hospitals will continue to treat workers' compensation patients.

Review of the hospital contracts and summaries received by the commission revealed that the average stop-loss threshold contained in those contracts is $39,524. Because the per diem reimbursements were derived from the hospital contracts, it is appropriate to use the average stop-loss threshold from the contracts. In addition, the analysis of the hospital per diem contracts revealed that the average percentage reimbursement paid after the stop loss threshold is met is 72%. As a result, in the proposed rule, 75% is set as the percentage of total audited charges to be paid after the stop loss threshold of $40,000 is reached. The stop loss threshold chosen increases hospital reimbursement and will ensure fair and reasonable rates for hospitals and ensure access to quality health care for injured workers by providing higher reimbursement for very high cost cases, ensuring that hospitals will continue to treat workers' compensation patients.

The proposed rule exempts from its provisions hospitals with 100 or less licensed beds. These hospitals are to be reimbursed at a fair and reasonable rate. Current §134.400 of this title exempts "small/rural" hospitals from the reimbursement provisions of the guideline. A "small/rural hospital" is defined in §134.400 as an acute care hospital having fewer than 100 beds and less than $1,000,000 total annual revenue as determined by an audited financial statement from the prior fiscal year. Under this definition, so few hospitals qualify for the exemption that it is essentially meaningless. The exemption in proposed §134.401 is specific and definite and excludes hospitals with 100 or fewer beds from the per diem rates. Contracts were not requested from these hospitals due to the small number of workers' compensation cases handled by such hospitals and the Commission has no data at this time to distinguish rural and non- rural hospitals with 100 beds or less. Reimbursement for these exempted hospitals is proposed to be at a fair and

reasonable rate. The exemption will ensure fair and reasonable rates for these hospitals and ensure access to quality health care for injured workers by ensuring that small hospitals will continue to treat workers' compensation patients.

The Commission will be reviewing the issue of small hospital exemption to determine if there is available relevant reliable data that it can obtain and analyze. The exemption for hospitals with 100 or fewer licensed beds may be deleted in its entirety, or may be deleted only for rural or only for non-rural hospitals. In addition, the Commission may receive or obtain information or data sufficient to establish a rate for hospitals with 100 or less licensed beds that may be the same as, or may differ from the rate established for other hospitals. Hospitals with 100 or less licensed beds are therefore encouraged to comment on the provisions of this rule proposal.

The Commission enlisted the expertise of Milliman and Robertson, Inc., one of the largest actuarial and management consulting firms in the United States to compare complexity of workers' compensation cases to managed care cases. A copy of this actuarial study is available at the Commission offices. The actuaries from Milliman and Robertson used two methods to analyze the complexity of workers' compensation as compared to managed care cases. The first method used overall average Medicare weights which were compared separately by category of service. The Milliman and Robertson analysis concluded that the more appropriate ratios are the separate ratios for medical and surgical; i.e. medical is compared to medical, and surgical is compared to surgical. The Commission agrees with this approach; the Commission has always proposed separate medical and surgical rates.

Milliman and Robertson utilized categories of hospital services, and analyzed the number of workers' compensation cases for each category of service for January through June of 1995, and the Medicare relative weight assigned compared with a similar analysis of the number of cases for an HMO/PPO case mix for the same period. When compared by category, none of the eleven categories are more complex for workers' compensation cases than for managed care cases as measured by Medicare weights. Milliman and Robertson concluded that the complexity of medical admissions for workers' compensation cases was just 79.9% of HMO/PPO cases unless rehabilitation cases were added to the medical cases in which case the workers' compensation cases would be 85.1% as complex as HMO/PPO cases. In addition, the analysis found that Texas workers' compensation surgical cases were 79% as complex as HMO/PPO surgical cases.

Milliman and Robertson also pointed out that Medicare weights represent not only the complexity of the particular DRG, but, in many cases, also the Medicare lengths of stay (LOS). For example, some DRGs have a higher relative weight, not because of complexity, but because the typical LOS is long. Thus, a higher weight does not necessarily mean the per day complexity would be at the same higher level. To correct for possible distortion because of Medicare length of stay (LOS), Milliman and Robertson used a second method to analyze the information. Medicare weights were divided by the average Medicare LOS. This calculation produces an average weight per day. For this analysis the LOSs for the managed care cases were estimated using Milliman and Robertson's hospital database for a managed care population in Texas. An overall LOS of 3.3 days was assumed with the average LOS of medical and surgical admissions at 3.9 days. The average LOS for workers' compensation cases was estimated using the overall LOS for 1995 based on the Commission's data (4.8 days for medical cases and 3.5 days for surgical cases). Milliman and Robertson adjusted their database to balance the average LOS to this experience. The results of the second analysis show that the complexity factor for medical admissions was .786 and the complexity factor for surgical admissions was .937. Both approaches clearly show, and Milliman and Robertson concluded that the complexity of workers' compensation cases for both medical and surgical stays is less than the complexity of typical managed care cases.

To determine whether the number of workers' compensation patients admitted to the hospital through the emergency room affects the validity of using managed care contracts in determining workers' compensation reimbursements, the Commission analyzed its data for the year 1995 by comparing the date of admission to the date of injury from hospital bills received by the Commission. A hospital admission on the same day of injury would tend to indicate an emergency room case. Only approximately 18.5% of the cases were hospital admissions occurring the same day of injury. It is likely that some of these cases are not cases which entered through the hospital emergency room, because for instance, there are some circumstances in which a treating doctor may examine an injured worker and then immediately refer the patient for hospital admission. Of the 18.5% of cases which possibly enter the hospital through the emergency room, 78% were trauma cases and 5% were burn cases. Both of these ICD-9 codes (trauma and burns) have been carved out of the per diem reimbursements set in the ACIHFG and are reimbursed at a fair and reasonable rate. Therefore, over 80% of the workers' compensation emergency room entries will not be governed by the per diem rates, but will be reimbursed on an individual basis at a fair and reasonable rate, and the validity of using managed care contracts in determining workers' compensation reimbursements is not affected by emergency admissions in the workers' compensation system.

The Workers' Compensation Act allows injured workers to choose their treating doctor, which necessarily leads to choice of hospital, because doctors are not automatically authorized to practice at every hospital. This means that carriers are unable to "steer' or require workers' compensation patients to obtain services at a particular hospital. Due to this aspect of the workers' compensation system, some critics contend that workers' compensation is unlike managed care where hospitals negotiate contract rates in part based on the ability of carriers to assure certain numbers of patients, thus encouraging hospitals to lower rates in anticipation of increased patient volume. Of the contracts for which full contract language (rather than a summary of contract terms) was provided to the Commission, only rarely was exclusivity included. Some contracts did provide incentives for staying within a particular healthcare network and some provided incentives for increased patient referrals. Although "steerage" of patients to a particular hospital for services may have been an important factor in negotiating hospital contracts in the early period of managed care contracting, the contract provisions indicate that it is less

of a factor in the determination of hospital contract rates in the current market.

Critics of the use of managed care contracts to determine workers' compensation reimbursement contend that managed care contracts were negotiated for a case mix different than workers' compensation and that workers' compensation reimbursement should therefore be greater than that in managed care contracts. The Legislature in Texas Labor Code §413.011 provided that the Commission establish fees which do not provide for payment of a fee in excess of the fee charged and paid for similar treatment of an injured individual of an equivalent standard of living or by someone acting on that individual's behalf. This standard may not allow the Commission to consider whether the fee to be paid under the contract was established with reference to other fees set for the same payor. If the fee is paid for similar treatment for managed care patients, the fee paid for workers' compensation claimants arguably should be no higher. The Commission recognizes that absolute compliance with this statutory prohibition is not possible, and believes that the legislature intended it as a strong policy objective to which the Commission should apply its judgment and expertise when balancing statutory standards and objectives. Strict adherence to this single provision could adversely affect access to quality health care and fair and reasonable fees which are also statutory criterion.

In recognition of the type of cases which may occur more frequently in workers' compensation than in some other systems, the proposed rule carves out some of the highest cost cases (trauma and burns) from the per diem reimbursement amount. This should compensate for any alleged additional reimbursement based on case mix, case complexity, or length of stay.

Analysis of the hospital contracts and summaries revealed that only 97 of the 1321 per diem contracts contained some form of tiered per diem for surgical admissions. A per diem rate is said to be "tiered" when there is a difference in reimbursement based on which day of the hospital stay is being reimbursed. Supporters of tiering of surgical per diem rates base the need for tiering on the contention that more hospital resources are expended on the day of surgery than on the following days. The Commission chose not to propose tiered per diems in this ACIHFG because, in the hospital contracts and summaries received by the Commission, tiering was not the predominant method of utilizing per diem reimbursements. The Commission has no information to indicate that the per diem rates in the non-tiered managed care contracts do not represent services with various lengths of stay and various types and severity of injury/illness, and, in fact, believes that they do. As only 4% of the managed care contracts carve out trauma, consideration of front loaded expense and severity must have been factors in negotiating the contract and thus in their negotiated per diem rates, and thus in the per diem rates proposed by the Commission. However, if there is front loaded expense and severity not accounted for in the managed care contracts, other provisions in the rule as proposed by the Commission will compensate for this, as they increase actual reimbursement. The Commission concludes that tiered surgical rates are not necessary for a rate to be fair and reasonable, or to ensure access to quality health care.

The review of the information from the hospital contracts and summaries received by the Commission revealed a variance in per diem reimbursements among hospitals. It has been suggested to the Commission that variations among contract rates is linked to hospital labor expenses, due to the fact that such expenses make up a major portion of total hospital expenses. Labor costs across regions as set out in the Bureau of Labor Statistics average hourly wage index for Texas metropolitan statistical areas (MSAs) were compared with the average hospital per diem rates contained in contracts for hospitals in the same region. No correlation between higher labor costs and higher per diem rates was observed; i.e. the higher per diem rates were not in the areas with higher labor costs. In fact, in some regions, there was a negative correlation þ a region with a low wage index and very high managed care contract rates.

To further evaluate the variances in managed care contract rates, the Commission identified hospitals that are in the same chain, and looked at the contract rates for different hospitals contracting with the same company in the same MSA; for the same hospital contracting with the same company in different MSA's; and for the same hospital contracting with different companies in the same MSA. The analysis revealed that there is no consistency among hospitals in the same chain of hospitals which are contracting with the same company in the same MSA; there is no consistency among a specific hospital's contracts with the same company in different MSA's; and there is no consistency among a specific hospital's contracts with different companies in the same MSA. While there may be some basis or explanation for the variation in contract rates across the state, it is not differences in geographic location.

Hospital type and hospital bed size were also compared with the hospital per diem rates contained in the contracts. Differences which may be attributable to hospital size have been recognized and accounted for by the proposed exemption for hospitals with 100 or less licensed beds from the per diem reimbursement rates in the proposed ACIHFG. (See discussion of exemption elsewhere in this preamble.) Differences in levels of care provided by some hospitals have been recognized and accounted for in the proposed ACIHFG by "carving out", or exempting from the per diem reimbursement rates, ICD-9 codes for trauma, burn and HIV cases. Other provisions in the proposed rule also serve to increase actual reimbursement. The Commission therefore concludes that regional rate variation is not necessary for a rate to be fair and reasonable, or to ensure access to quality health care.

Inflation factors are not the same each year, and in fact they can indicate decreases as well as increases in costs. Such factors cannot be accurately predicted into the future, and the Commission has not proposed an automatic predetermined adjustment in the reimbursement rates provided in the proposed ACIHFG.

Because the Bureau of Labor Statistics (BLS) Medical Care Services Consumer Price Index (CPI) is merely a reflection of household expenditures for health insurance premiums and out-of-pocket medical expenses, it is not necessarily indicative of hospital costs and does not necessarily indicate that hospitals should receive greater reimbursements. In view of this, the Commission did not directly use the Medical Care Services

CPI to determine hospital reimbursement rates in the proposed ACIHFG.

Nonetheless, the Medical Care Services CPI is commonly used as an indicator of inflation in costs to provide medical services and if applied, the hospital reimbursements in the new ACIHFG are sufficient to account for the inflation of 12% reflected in the CPI for the period from 1993 to 1996, and the proposed ACIHFG's estimated 14.3% increase over rates contained in the current ACIHFG (which percentage does not account for any possible increased reimbursement due to the 100-bed exemption) is just under the Medical Care Services CPI of 18% for the period 1993 to 1996.

In addition, the Commission will continue to analyze the newer per diem managed care contracts for the period October 1995 through October 1996 as they are received

After determining what the per diem rates would be, based on the managed care contracts, the Commission wanted to compare those rates to Medicare rates. Because hospitals do a large volume of Medicare services and accept Medicare payment rates, the Commission believes that Medicare rates are fair and reasonable payment for Medicare patients, and ensure Medicare patients access to quality health care. The Medicare fee program is also designed to achieve effective cost control, another statutory factor the Commission must try to meet in its own fee guidelines. Finally, the Commission believes that Medicare patients are persons of an equivalent standard of living to workers' compensation patients. A study of the differences in "standards of living" between those over and under 65 years of age was completed based separately upon considerations of income and consumption. This study concluded that the population over 65 years of age has a higher standard of living than the under 65 years of age working population. Therefore, the Medicare population is at least of an equivalent standard of living, and rates paid on their behalf for medical services are relevant to fair and reasonable rates for workers' compensation patients. For these reasons, it is relevant to consider estimated Medicare per diem rates. No hospital is required to participate in the Medicare program. The fact that hospitals accept Medicare rates (particularly for-profit hospitals), and the fact that Medicare reimbursements make up 40% of the gross patient revenue for Texas hospitals also indicates that Medicare rates are fair and reasonable.

To compare the proposed ACIHFG rates with Medicare rates, the Commission again enlisted the expertise of Milliman and Robertson, Inc. A copy of this actuarial report is available for inspection at the Commission offices. Milliman and Robertson performed an actuarial study which calculated the estimated per diem rates at 1996 Medicare payment levels for five Medicare diagnostic related groups (DRGs 214 Back & Neck Procedures with complications, 215 Back & Neck Procedures without complications, 219 Lower Extremity & Humerus Procedure except Hip, Foot, Femur Age >17 without complications, 231 Local Excision & Removal of Internal Fixation Devices except Hip & Femur, and 243 Medical Back Problems). An analysis of TWCC's database shows that these five DRGs would have been the top five DRGs and would have accounted for approximately 60% of workers' compensation inpatient hospital payments in calendar year 1995 if a DRG descriptor were applied to Texas workers' compensation cases that year. The Milliman and Robertson study calculated Medicare per diem equivalent rates by starting with the 1996 Medicare base rate and multiplying this base rate by the 1996 Medicare weight which is divided by the Medicare average length of stay to arrive at the estimated Medicare-based per diem amounts.

This study shows that, for the five DRGs studied and adjusted for Medicare LOS, under the per diem reimbursements contained in the proposed rule, hospitals will receive higher reimbursement for workers' compensation patients than they do for Medicare patients. This reinforces the Commission's conclusion that the per diem rates derived from the managed care contracts are fair and reasonable, will ensure access to quality medical care, will achieve effective cost control, and will not pay in excess of the amount that would be paid for similar treatment of non-workers' compensation patients of an equivalent standard of living.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed rule is in effect there will be fiscal implications to some units of state and local governments as a result of enforcing or administering the rule.

There will be no addition or reduction in cost to the state or to units of local government expected as a result of enforcing or administering the rule. Any increased or decreased cost to the state as the employer/carrier for state employees will be the same as that described for insurance carriers later in this preamble.

State-owned hospitals and units of local government that are hospital districts will experience the same increased/reduced revenue as that described for hospitals later in this preamble.

Ms. Chamness also has determined that for each year of the first five years the rule as proposed is in effect the public benefit and costs anticipated as a result of enforcing the rule will be as follows.

(a) The public benefit expected as a result of adoption of the proposed rule is as follows.

(1) The Commission will comply with the statute requiring the adoption of fair and reasonable rates.

(2) Persons required to pay for inpatient hospital services, including employers, insurance carriers, the State of Texas and local governments, will pay fair and reasonable amounts for workers' compensation claimants which are similar to that paid for other patients.

(3) Hospitals will receive a fair and reasonable amount in compliance with the statute.

(4) Claimants will have access to quality health care services.

(5) The guideline will be updated to provide for reimbursement amounts implementing medical cost containment measures designed to assure quality of medical care as required by the Workers' Compensation Act.

(6) It is anticipated that clear, fair guidelines will minimize disputes and encourage prompt payments to hospitals.

(b) The probable economic costs to persons required to comply with the rule are as follows.

(1) Compared with current §134.400 of this title, there is no additional bill processing cost attributable to this proposed new rule, with the exception of costs to reprogram computer payment systems.

(2) It is anticipated that there will be a minimal charge for copies of the fee guideline. This charge will be consistent with the requirements of state law for charging for copies of documents.

(3) It is estimated that the proposed new §134.401 will result in an approximate 14.3% increase in reimbursement to hospitals for inpatient services, which equates to a less than 1% increase in costs to the workers' compensation system as a whole. This increase in system costs may be less than the estimated 1% because of changes in the reimbursement system. The proposed new rule establishes reimbursement as the lesser of: a pre-negotiated workers' compensation contract rate between the hospital and the insurance carrier, the hospital's usual and customary charges, or the reimbursement set out in the guideline. This provision changes the current practice of paying the guideline's per diem reimbursement amount even when it is more than a hospital's billed charges. This change from the current guideline will result in a savings to the system. In addition, the ability of hospitals to negotiate rates which are less than the per diem set in the guideline may also result in savings to the system.

(4) Insurance carriers will experience an approximated 14.3% increase in hospital inpatient reimbursements as a result of the proposed guideline and may experience costs to reprogram computer payment systems. However, the 14.3% increase may be reduced based on the factors discussed in the preceding paragraph.

(5) Insurance carriers may experience an increase in costs, associated with the carve out of additional items which will require review during bill audits. The Commission is unable to quantify this increase.

There will be no difference in costs of compliance for small businesses as compared to large businesses. Hospitals with 100 beds or less are exempted from the guideline and will be reimbursed at a fair and reasonable rate as provided by statute.

Comments on the proposal must be submitted to Elaine Crease by 5 p.m. on Thursday, March 13, 1997 at Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

Based upon comments received and the staff's or Commissioner's review of those comments, or based upon action by the Commissioners at the public meeting, the rule as adopted may differ from the rule as proposed, including, but not limited to, the following: fee amounts in this proposed new guideline may change, items carved out may change, stop-loss threshold may change, the Commission may establish regional variations in fees, and/or the Commission may establish a tiered per diem for surgery. Persons in support of the fee amounts proposed or opposed to regional fee variations and/or a tiered surgical per diem may wish to comment to that effect. Persons submitting comments in favor of regional variation of hospital reimbursements or alternative methodology such as tiered per diems for surgery should include the proposed methodology, how the methodology would vary the reimbursement proposed and provide data to support the alternative methodology.

The rule as proposed exempts from the guideline hospitals with 100 or less licensed beds. The Commission does not have sufficient data at this time to substantiate that fees based on contracts from hospitals with more than 100 licensed beds are fair and reasonable for smaller hospitals. Commenters are encouraged to provide reliable, verifiable data relating to this issue. If verifiable data and information is received which can be used to establish fair and reasonable rates, or which sufficiently demonstrates that reimbursement for hospitals with 100 or less licensed beds can validly be based on average managed care contract fees for hospitals with over 100 licensed beds, the exemption for smaller hospitals may be deleted. Submission of data and information regarding hospitals with 100 or less licensed beds in rural areas and those in non-rural areas is also encouraged, as the Commission has been urged to exempt only those in rural areas. The Commission will also be reviewing this issue to determine if there is available relevant reliable data that it can obtain and analyze. The exemption for hospitals with 100 or fewer licensed beds may be deleted in its entirety, or may be deleted only for rural or only for non-rural hospitals. In addition, the Commission may receive or obtain information or data sufficient to establish a rate for these hospitals that may be the same as, or may differ from the rate established for other hospitals. Hospitals with 100 or less licensed beds are therefore encouraged to comment on the provisions of this rule proposal.

The Commission encourages submission of verified contracts or contract data not already submitted to TWCC relating to the period October 1, 1995 through October 1, 1996 with comments. Verification should include the signature under oath of an authorized person who can assure the authenticity and the accuracy of the contract data. Persons submitting comments regarding financial considerations of the rule are requested to provide data to support their positions which can be substantiated by the Commission. Commenters are encouraged to provide to the Commission with their comments the source of the data, the entity issuing the data and its address, the date the data was issued, and any information indicating how the data was determined to be valid or could be substantiated by the Commission.

A public hearing regarding this rule will be scheduled in the near future, in Room 910A of the Commission's central office in the Southfield Building, 4000 South IH-35, Austin, Texas. Persons interested in attending the hearing should contact the Executive Communication Division at (512) 707-5690 for the date and time of the hearing. Commenters are encouraged to provide to the Commission with their comments the source of any data used, the entity issuing the data and its address, the date the data was issued and any information indicating how the data was determined to be valid or could be substantiated by the Commission. Please also see the previous paragraph in this preamble.

28 TAC §134.400

The repeal is proposed under the Texas Labor Code, §402.061 which requires the Commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required

by the nature of the injury as and when needed; the Texas Labor Code, §413.007, which requires the Commission to maintain a statewide database of medical charges, actual payments, and treatment protocols; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; and the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines.

This proposed new rule and repeal of existing rule §134.400 affect the following statutes: the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code, §413.002, which requires that the Commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with Commission rules; the Texas Labor Code, §413.007, which sets out information to be maintained by the Commission's Medical Review Division; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines; the Texas Labor Code, §413.013, which requires the Commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments, refunds or overpayments; and the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution.

§134.400. Acute Care Inpatient Hospital Fee Guideline.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701433
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Earliest possible date of adoption: March 14, 1997
For further information, please call: (512) 440–3700

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28 TAC §134.401

The new rule is proposed under the Texas Labor Code, §402.061 which requires the Commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code, §413.007, which requires the Commission to maintain a statewide database of medical charges, actual payments, and treatment protocols; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; and the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines.

This proposed new rule and repeal of existing rule §134.400 affect the following statutes: the Texas Labor Code, §408.021, which entitles injured employees to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code, §413.002, which requires that the Commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with Commission rules; the Texas Labor Code, §413.007, which sets out information to be maintained by the Commission's Medical Review Division; the Texas Labor Code, §413.011, which provides that the Commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires periodic review of the medical policies and fee guidelines; the Texas Labor Code, §413.013, which requires the Commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments, refunds or overpayments; and the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution.

§134.401. Acute Care Inpatient Hospital Fee Guideline.

(a) Applicability.

(1) This guideline shall become effective June 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the effective date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act. Medical and/or surgical inpatient services rendered prior to the effective date of this rule shall be subject to the ACIHFG in effect at the time the services were rendered. These rules shall not apply to acute care hospitals with 100 or less licensed beds which shall be reimbursed at a fair and reasonable rate.

(2) Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of Service - Code
Rehabilitation - Inpatient - IR
Psychiatric - Inpatient - IP

(3) Services such as outpatient physical therapy, radiological studies, and laboratory studies are not covered by this guideline

and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of Service - Code
Hospital Surgical - Outpatient - HS
Hospital Other - Outpatient - HO
Ambulatory Surgical - Outpatient - AS
Ambulatory Other - Outpatient - AO

(4) Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. For these type of admissions, insurance carriers shall put one of the appropriate following codes on each bill to indicate the type of services performed:
Type of Service - Code
Ambulatory Surgical - Outpatient - AS
Ambulatory Other - Outpatient - AO

(5) Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services. Except as listed in subsection (c)(4)(B) of this section, emergency transportation shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline in effect at the time the services are rendered.

(b) General Ground Rules.

(1) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(A) Acute Care Hospital - A health care facility that provides inpatient or outpatient services delivered to patients experiencing acute illness or trauma as licensed by the Texas Department of Health (TDH) as a General or Special Hospital Type.

(B) Inpatient Services - Health care rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.

(C) Institutional Services - All non-physician services rendered within the hospital by an employee or agent of the hospital.

(D) Length of Stay (LOS) - Number of calendar days from admission to discharge. In computing a patient's length of stay, the day of admission is counted, but the day of discharge is not.

(E) Medical Admission - Any hospital admission where the primary services rendered are medical in nature.

(F) Stop-Loss Payment - An independent method of payment for an unusually costly or lengthy stay.

(G) Stop-Loss Reimbursement Factor (SLRF) - A factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(H) Stop-Loss Threshold (SLT) - Threshold of total charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor by the total charges identifying that particular threshold.

(I) Surgical Admission - Any hospital admission where the primary services rendered are surgical in nature. The surgical nature of the service is indicated by the use of a surgical procedure code.

(J) Standard Per Diem Amount (SPDA) - A standardized per diem amount established by the Commission as the maximum reimbursement for hospital services covered by this guideline.

(2) General Information.

(A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:

(i) a rate for worker's compensation cases prenegotiated between the carrier and hospital;

(ii) the hospital's usual and customary charges; or

(iii) reimbursement as set out in subsection (c) of this section for that admission.

(B) Additional reimbursements as outlined in subsection (c)(4) of this section are determined on a case-by-case basis within the guidelines established for the specific services rendered.

(C) All charges submitted are subject to audit as described in Commission rules.

(D) All bills for professional services rendered by a health care provider shall be submitted on form TWCC-67, the standard HCFA 1500 form.

(E) All bills for acute care hospital inpatient services shall be submitted on form TWCC-68a, the standard UB-92 (HCFA 1450) form. Depending upon the type of service(s) rendered, the appropriate code shall be included on each UB-92 (HCFA 1450) submitted. One of the following codes shall be put on the bill by the insurance carrier:
Type of Service - Code
Acute Care - Inpatient (Medical) - IM
Acute Care - Inpatient (Surgical) - IS

(F) When a medical admission takes place, and surgery is subsequently performed during this stay, the entire stay is considered to be a surgical admission.

(c) Reimbursement.

(1) Standard Per Diem Amount . The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows:
Medical - $ 870
Surgical - $ 1,045
Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) - $ 1,560

(2) Method. All inpatient services provided by an acute care hospital for medical and/or surgical admissions will be reimbursed using a service related standard per diem amount.

(A) The complete treatment of an injured worker is categorized into two admission types: medical or surgical. A per diem amount shall be determined by the admission category.

(B) A per diem amount is also established for reimbursement of each specific ICU/CCU day independently. This special per diem rate is used for each ICU/CCU day in lieu of

the specific (medical/surgical) per diem rate being used for normal services rendered during this admission.

(C) Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection or if the ICD-9 primary diagnosis code is listed in paragraph (5) of this subsection.

(3) Reimbursement Calculation.

(A) Explanation.

(i) Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical).

(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.

(iii) If applicable, ICU/CCU days are subtracted from the total LOS and reimbursed the ICU/CCU per diem rate for those specific days of treatment in lieu of the assigned medical/surgical per diem rate.

(iv) The Workers' Compensation Reimbursement Amount (WCRA) is the total amount of reimbursement to be made for that particular admission.

(B) Formula. LOS x SPDA = WCRA.

(C) Examples.

(i) Without ICU/CCU days: admission category - medical; length of stay - eight days; per diem (medical) - $870; eight days at $870 equals $6,960.

(ii) With ICU/CCU days: admission category - surgical; length of stay - 15 days; ICU/CCU days - three days; per diem (surgical) -$1,045; per diem (ICU/CCU) - $1,560. Fifteen total days minus three ICU/CCU days equals 12 surgical days. Twelve days at $1,045 plus three days at $1,560 equals $17,220.

(4) Additional Reimbursements. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

(A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%:

(i) Implantables (revenue codes 275, 276, and 278); and

(ii) Orthotics and prosthetics (revenue code 274).

(B) When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate:

(i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619);

(ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352, 359);

(iii) Hyperbaric oxygen (revenue code 413);

(iv) Blood (revenue codes 380-399); and

(v) Air ambulance (revenue code 545).

(C) Pharmaceuticals administered during the admission and greater than $250 per dose shall be reimbursed at cost to the hospital plus 10%.

(5) Reimbursement for Certain ICD-9 Codes. When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate:

(A) Trauma (ICD-9 codes 800.0-959.50);

(B) Burns (ICD-9 codes 940-949.9); and

(C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9).

(6) Stop-Loss Method. Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. The diagnosis codes specified in subsection (c)(5) of this section are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.

(A) Explanation.

(i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.

(ii) This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

(iii) If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%.

(iv) The Stop-Loss Reimbursement Factor is multiplied by the total audited charges to determine the Workers' Compensation Reimbursement Amount (WCRA) for the admission.

(v) Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television). If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted. Items and services which are not related to the compensable injury may be deducted. The formula to obtain audited charges is as follows: Total Charges - Deducted Charges = Audited Charges.

(B) Formula. Audited Charges x SLRF = WCRA.

(C) Example.
Total Charges: - $108,000
Deducted Charges: - $8,001
Audited Charges: - $99,999
$99,999 x .75 equals $74,999.25 (WCRA).

(7) Reimbursement for Other Services.

(A) Professional Services. All professional services performed by a health care provider shall be reimbursed in accordance with the Texas Workers' Compensation Commission Medical Fee Guideline currently in effect.

(B) Pharmacy Services. Pharmaceutical services rendered as part of inpatient institutional services are included in the basic reimbursement established by subsection (c)(1) of this section. Pharmaceutical services shall not be reimbursed separately except as listed in subsection (c)(4)(C) of this section.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701434
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Earliest possible date of adoption: March 14, 1997
For further information, please call: (512) 440–3700

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

Part I. Texas Department of Human Services

Chapter 12. Special Nutrition Programs

Child and Adult Care Food Program

40 TAC §§12.3, 12.5, 12.6, 12.14, 12.15, 12.19, 12.20, 12.24-12.26

The Texas Department of Human Services (DHS) proposes amendments to §§12.3, 12.5, 12.6, 12.14, 12.15, 12.19, 12.20, and 12.24-12.26, concerning eligibility of contractors, facilities, and food service management companies, application for program benefits - contractors, agreement, meal requirements, reimbursement methodology, program benefits, training/technical assistance, sanctions and penalties, denials and terminations, and appeals, in its Special Nutrition Programs chapter. The purpose of the amendments is to mandate program training for Child and Adult Care Food Program (CACFP) contractors who sponsor child and adult care centers, as well as those who sponsor day care homes; require all food service management companies (FSMCs) to register with DHS prior to contracting for meal service with CACFP child and adult care centers to provide meals; and require private non-profit CACFP contractors who sponsor day care homes to obtain a performance bond if they have less than three years administrative and financial history.

Terry Trimble, interim commissioner, has determined that for the first five-year period the proposed sections will be in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Trimble also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be increased efficiency and increased accountability for public funds. The mandated training will enhance service to child and adult care center clients and reduce errors found during program audits and reviews. Registering FSMCs will enhance the meal service to CACFP clients, ensure that FSMCs are able to meet CACFP regulations, state and local health standards, and reduce adverse findings during program reviews and audits. Requiring day care home sponsors with limited experience to obtain performance bonds will safeguard public funds. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections relating to training, and the use of registered FSMCs for child and adult care center sponsors. The anticipated economic cost to persons who are required to comply with the proposed sections relating to performance bonds for family day care home sponsors is expected to be approximately 2 1/2 % of the value of their contract.

Questions about the content of the proposal may be directed to Keith N. Churchill at (512) 467-5837 in DHS's Special Nutrition Programs. Written comments on the proposal may be submitted to Supervisor, Rules Unit, Media and Policy Services-126, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register*.

The amendments are proposed under the Human Resources Code, Title 2, Chapters 22 and 33, which provides the department with the authority to administer public and nutritional assistance programs.

The amendment implements §§22.001-22.030 and 33.001-33.024 of the Human Resources Code.

§12.3. Eligibility of Contractors ***,*** *[and] Facilities****, and Food Service Management Companies****.*

(a) (No change.)

(b) To be eligible to participate in the CACFP as a day care home sponsor, applicants must:

(1)-(2) (No change.)

(3) submit a comprehensive financial statement showing all expenditures and sources of income to the organization for the three years preceding the year for which application is made. Non-governmental entities with fewer than three years of administrative and financial history that apply **or reapply** to participate in the CACFP as day care home contractors must submit a performance bond in an amount equal to the value of the contractor's projected annual level of reimbursement as determined by DHS. The performance bond must be obtained from a company designated in United States Treasury Circular 570 as certified to issue bonds for federally funded programs. Contractors required to submit a performance bond as a condition of eligibility [for their initial application] must submit a performance bond as a condition of eligibility for each contract renewal until relief from the bonding requirement has been granted, and must adjust the amount of the performance bond based on fluctuations in the value of the contract as determined by DHS. Contractors subject to the bonding requirement who have, at the time of application **or reapplication**, less than three but more than two years of administrative and financial history, may request relief from the bonding requirement after 12 months of successful program participation. Contractors who have less than two, but more than one year of administrative and financial history, may request relief from the bonding requirement after 24 months of successful program participation. Contractors who have less than one year of administrative

and financial history may request relief from the bonding requirement after 36 months of successful program participation. DHS grants relief from the bonding requirement based on the above schedule and the contractor's successful program operation;

(4) (No change.)

(5) maintain a secondary business office physically located in each DHS region in which they sponsor a day care home to conduct program management functions, except that a secondary business location is not required in the DHS region in which a sponsor's primary business office is located. An appropriate representative of the contractor must be available to DHS staff and providers during normal business hours. Normal business hours are 8:00 a.m. through 5:00 p.m., Monday through Friday. Contractors are considered to be available to DHS staff and providers if a representative of the contractor can be contacted by telephone at the secondary business location during normal business hours, or if the contractor has established a procedure which allows DHS staff and providers to leave a voice message at the secondary business location, and the contractor returns the call not later than 24 hours from the time the voice message is left. Contractors must notify DHS in advance of their intent to change a secondary business location; **and**

[(6) participate in program and program related training deemed reasonable and necessary by DHS; and]

(6)[(7)] submit a uniform set of management information each month, as described in §12.9 of this title (relating to Reporting and Record Retention), in fixed length, ASCII-Text (Standard Data File) format.

(c) Facilities must be licensed or otherwise approved by federal, state, or local authorities. Adult day care centers must be licensed by **DHS or the Texas Department of Mental Health and Mental Retardation (TxMHMR)** [the Texas Department of Health (TDH)], except that receipt of Title XIX funds (Medicaid) constitutes approval for program participation. Child care centers must be licensed or registered by DHS. General Exception: Facilities operated by federal and Indian tribal governments are not required to be licensed or otherwise approved by DHS or **TxMHMR** [TDH].

(d) To be eligible to participate in the CACFP, contractors must participate in program and program-related training deemed reasonable and necessary by DHS.

(e) To be eligible to participate in the CACFP as a sponsor of child or adult care centers, contractors who purchase meals from a food service management company (FSMC) must purchase such meals only from a FSMC that is:

(1) currently registered with DHS; or

(2) exempt from registration.

(f) To be eligible to provide food service to a contractor sponsoring the participation of child or adult care centers, FSMCs except public institutions, including but not limited to schools and hospitals, must register with the DHS's Special Nutrition Programs according to the stipulations and conditions listed in paragraphs (1)-(4) of this subsection.

(1) DHS approves applications for registration for a period not to exceed one year, with registrations expiring on March 14 of each year. The effective date of registration is the date DHS approves the application. FSMCs must reapply for registration each fiscal year.

(2) A registered FSMC must request the addition of a new or previously unregistered food preparation facility to its current registration prior to providing meals from such a facility to a child or adult care center participating in the CACFP;

(3) DHS conducts a preapproval visit to the FSMC and each food preparation facility to validate the information provided by the FSMC prior to approval of the application. The new facility cannot be approved retroactively.

(4) FSMCs applying for registration to provide food service to contractors sponsoring the participation of child and adult care centers in the CACFP, or applying to add a new or previously unregistered food preparation facility, must provide documentation of:

(A) the number of food preparation facilities under their direct control;

(B) compliance with state and local health and sanitation requirements at each food preparation facility;

(C) the number of meals the FSMC can produce daily at each food preparation facility;

(D) the ability of the FSMC to provide special diets to meet medical or religious needs;

(E) the ability of the FSMC to safely transport meals; and

(F) the availability of a registered dietitian for consultation.

(g)[(d)] DHS requires contractors to submit as proof of eligibility one or more of the following forms of documentation of tax-exempt status:

(1) letter from the IRS notifying the contractor that he has been granted tax-exempt status under the Internal Revenue Code of 1954;

(2) proof of participation in another federal program that requires non-profit status; and/or

(3) letter from the IRS acknowledging acceptance of the contractor's application for tax-exempt status under the Internal Revenue Code of 1954.

(h)[(e)] To be eligible to participate in the CACFP as a day care home sponsor, contractors must demonstrate their ability to perform according to the standards specified in §12.5 (b) of this title (relating to Application for Program Benefits - Contractors). In addition, contractors must provide as proof of their current tax-exempt status not less frequently than annually, a copy of their most recent IRS Form 990 (Return of Organization Exempt From Income Tax) submitted to the Internal Revenue Service.

(i)[(f)] DHS requires applicants/contractors that are proprietary, for-profit entities to submit as proof of eligibility, a letter certifying that at least 25% of the enrollment or licensed capacity of the facility or facilities for which the contractor is making application received benefits under Title XX of the Social Security Act in the month before the month in which the application is submitted.

(j)[(g)] DHS requires contractors to submit copies of a current licensure or registration to operate a day care facility when they:

(1) apply to participate in the CACFP; or

(2) receive a renewed or amended license or registration.

(k)[(h)] Contractors are ineligible for the CACFP if they have permitted a member of the governing body, an agent, a consultant, or an employee of the contractor to enter the facility when children are present and any of these persons have been convicted of:

(1) a felony or misdemeanor classified as an offense against the person or the family, or as public indecency; or

(2) a felony violation of any statute intended to control the possession or distribution of a substance included in the Texas Controlled Substances Act.

(l)[(i)] Contractors are ineligible for the CACFP if they have permitted a member of the governing body, an agent, a consultant, or an employee of the contractor to engage in any activity related to the administration of the CACFP and any of these persons have been convicted of a fraudulent activity, including cases in which adjudication is deferred.

(m)[(j)] Contractors are ineligible for the CACFP if they sponsor the participation of a day care home which, after being afforded due process by the contractor, has been terminated for cause, including but not limited to program abuse, deficient program operation, and fraudulent activities, unless DHS has granted prior approval.

(n)[(k)] DHS requires contractors to submit documentation of compliance with the requirements of the Single Audit Act. Contractors must submit as proof of eligibility one or more of the forms of documentation of compliance specified in paragraphs (1)-(3) of this subsection:

(1) a copy of an audit for a specific contractor fiscal year which has been determined to meet the requirements of the Single Audit Act;

(2) a completed DHS Single Audit Identification Data form containing assurance that the contractor will obtain an acceptable audit which will meet the requirements of the Single Audit Act; or

(3) documentation that the contractor is not subject to the Single Audit Act.

§12.5. Application for Program Benefits - Contractors.

(a)-(c) (No change.)

(d) Contractors applying to sponsor the participation of child and adult care centers in the program must include sufficient information in their applications to demonstrate how they will:

(1) conduct preapproval visits of food service management companies (FSMCs) to determine their suitability and capacity to provide food service according to §12.3 of this title (relating to Eligibility of Contractors and Facilities), prior to awarding a contract;

(2) review the FSMCs and ensure that program deficiencies discovered during a review or by other means are corrected according to §12.19 of this title (relating to Program Reviews); and

(3) terminate the FSMC's contract for failure to comply with program requirements according to §12.25 of this title (relating to Denials and Terminations).

(e)[(d)] If a contractor's application for participation is incomplete, DHS will deny the application if the requested additional information is not submitted to DHS within 30 days of the date of the written request. The contractor may reapply when all required information and documentation is available.

(f)[(e)] To be eligible for start-up funds or expansion funds, contractors that sponsor day care homes must submit an application. DHS approves or denies applications for start-up and expansion funds according to 7 Code of Federal Regulations §§226.6, 226.12, 226.15, 226.16, and 226.23.

(1) Start-up funds are available only to sponsors of day care homes or contractors that are attempting to add day care homes to their operation.

(2) Expansion funds are available only to contractors that have sponsored day care homes for at least one year at the time of application and may be used only to expand program operations in low-income and/or rural areas. DHS considers the anticipated amount of expansion funds and alternate sources of funds when evaluating an applicant sponsor's plan for expansion. Contractors that are eligible to receive expansion funds may receive expansion funds only once. Applications for expansion funds must include:

(A) an acceptable and realistic plan for recruiting day care homes to participate in the program, including activities which the sponsoring organization will undertake;

(B) the amount of expansion funds needed and a budget detailing the costs the organization will incur, document, and claim;

(C) the time necessary for the expansion of program operations; and

(D) documentation that the expansion area meets the definition of a rural or low-income area.

§12.6. Agreement.

(a) (No change.)

(b) Contractors that purchase meals from a food service management company **(FSMC)** or school food authority must enter into **an agreement** [agreements] according to 7 Code of Federal Regulations §§226.17, 226.19, 226.19a, and 226.21. **The agreement must contain at minimum the provisions stated in paragraphs (1)-(15) of this subsection:**

(1) the beginning and ending dates of the agreement;

(2) the unit price per meal;

(3) a requirement that the FSMC provide special diets as specified by the contractor for medical or religious reasons;

(4) a description of the method the FSMC will use to transport food;

(5) a requirement that the FSMC will ensure that all meals meet United States Department of Agriculture (USDA) meal pattern requirements;

(6) a requirement that the FSMC will maintain all records specified by USDA, DHS, or the contractor;

(7) an assurance that the FSMC will provide USDA, DHS, the contractor, or their designated representative, access at a reasonable time, to all FSMC facilities and records and shall allow the records to be reviewed and copied as deemed necessary to complete a review, audit, or other evaluation of compliance with program and contract requirements;

(8) a requirement that the FSMC correct program deficiencies by a specified date;

(9) a statement that the agreement is subject to availability of federal funds;

(10) a statement that the agreement may be canceled by either party upon 30 days written notice, by mutual consent, or for failure to correct program deficiencies by the date specified by the contractor. The contractor may terminate the agreement without further notice if the health and safety of clients are at risk;

(11) a requirement that the contractor and FSMC perform according to state and federal laws, rules, and regulations;

(12) a requirement that the FSMC provide the contractor monthly billing records by a specified date. Failure to provide billing records may result in nonpayment or termination of the agreement;

(13) a requirement that the FSMC comply with, and provide documentation of compliance with, all relevant state and local health standards;

(14) a requirement that the FSMC participate in any evaluation study mandated by DHS; and

(15) a requirement that the FSMC may not subcontract for any portion of the food service agreement without specific, written permission of the contractor.

(c)-(g) (No change.)

§12.14. Meal Requirements.

(a) Contractors must ensure that all program meals served and claimed for reimbursement fulfill the requirements of 7 Code of Federal Regulations §§226.2, 226.6, 226.15- 226.20, and 226, Appendix A, Alternate Foods for Meals**, including meals purchased from a food service management company**.

(b)-(c) (No change.)

§12.15. Reimbursement Methodology.

(a)-(f) (No change.)

(g) Contractors that sponsor child and adult care centers may not include in a claim for reimbursement any meals:

(1) purchased from a food service management company (FSMC) that is not registered with DHS on or before the date of the meal service; or

(2) prepared at an unapproved food preparation facility operated by a registered FSMC.

§12.19. Program Reviews.

(a)-(e) (No change.)

(f) Contractors that sponsor the participation of child and adult care centers must:

(1) conduct a preapproval visit to each food preparation site and the administrative offices of the food service management company (FSMC) prior to awarding a contract for food service;

(2) review the FSMC, including each food preparation site and administrative offices, at least three times per contract period. The first review must occur within the first six weeks of the beginning of the program year, and no more than six months can pass between reviews. If a food service contract is executed after the beginning of the contract period, the contractor may adjust the number of reviews based on the number of months remaining in the contract period;

(3) review the FSMC meal preparation and delivery system, including but not limited to sanitation and food preparation practices, transportation of food, record keeping, and compliance with state and local health requirements;

(4) maintain written verification of monitoring visits, including the date of the visit and all findings; and

(5) require the FSMC to take appropriate action to correct all deficiencies discovered during the review within a reasonable amount of time. If the health and well being of program participants are at risk as a result of program deficiencies identified during a FSMC review, the contractor may immediately terminate the contract for cause.

§12.20. Training/Technical Assistance.

Contractors must provide training and technical assistance deemed reasonable and necessary by the Texas Department of Human Services to their facilities according to 7 Code of Federal Regulations §§226.6, 226.16, and **226.18-19a** [226.18].

§12.24. Sanctions and Penalties.

(a)-(c) (No change.)

(d) If a **contractor** [family day care home (FDCH) sponsor] fails to attend training designated by DHS as mandatory, DHS will immediately declare the contractor seriously deficient and terminate the contractor's agreement. DHS will deny payment of any administrative costs claimed for reimbursement beginning with the first month after the month in which the contractor failed to attend the required training. DHS will notify the contractor's eligible providers that they may transfer to another approved sponsor.

(e)-(m) (No change.)

§12.25. Denials and Terminations.

(a)-(k) (No change.)

(l) DHS denies or revokes the registration of a food service management company (FSMC) for failure to demonstrate its ability to perform according to program requirements, or for failure to submit all necessary documentation to complete the application within 60 calendar days. DHS may deny participation to a FSMC or any combination of its food preparation facilities. If DHS denies the application, the FSMC may not reapply for the remainder of the fiscal year in which the application was submitted. A FSMC may appeal the denial or revocation of registration according to §12.26 of this title (relating to Appeals).

§12.26. Appeals.

(a) Contractor **and food service management company** appeals of Texas Department of Human Services (DHS) actions are conducted according to 7 Code of Federal Regulations §226.6 and §79.1602 of this title (relating to Right to a Hearing). DHS requires that contractors appealing actions taken by DHS based on the findings of federal audits request a hearing to be conducted by the United States Department of Agriculture (USDA).

(b)-(d) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701502
Glenn Scott
General Counsel, Legal Services
Texas Department of Human Services
Proposed date of adoption: May 1, 1997
For further information, please call: (512) 438–3765

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Chapter 72. Memorandum of Understanding with Other State Agencies

Memorandum of Understanding Concerning the Capacity Assessment of Persons Who Are Elderly and Persons with Mental Retardation and/or Developmental Disabilities

40 TAC §72.501

The Texas Department of Human Services (DHS) proposes an amendment to §72.501, concerning a uniform assessment tool for assessing decision-making capacity, in its Memoranda of Understanding with Other State Agencies chapter. The purpose of the amendment is to define who may initiate and administer the assessment tool and require the departments to write a final report on the pilot study of the tool and to implement use of the tool at nursing facilities, licensed by DHS, and residential services facilities, certified by, operated by, or contracting with the Texas Department of Mental Health and Mental Retardation.

Terry Trimble, interim commissioner, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Mr. Trimble also has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be provision of a uniform and thorough process for evaluating a nursing facility resident's need for guardianship referral to probate court. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed section.

Questions about the content of this proposal may be directed to Wendy Francik at (512) 438-3167 in DHS's Long Term Care Policy Section. Written comments on the proposal may be submitted to Supervisor, Rules Unit, Media and Policy Services-114, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714- 9030, within 30 days of publication in the *Texas Register*.

The amendment is proposed under the Health and Safety Code, §533.044, and the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The amendment implements the Health and Safety Code, §533.044, and the Human Resources Code, §§22.001-22.030.

§72.501. Uniform Assessment Tool for Assessing Decision-Making Capacity.

(a) Introduction and legal authority. The Texas Department of Mental Health and Mental Retardation (TDMHMR) and Texas Department of Human Services (TDHS)(the agencies) by rule adopt a joint memorandum of understanding (MOU) as required by the Texas Health and Safety Code, §533.044 which requires the use of a uniform assessment tool to assess whether an elderly person, a person with mental retardation, a person with a developmental disability, or a person who is suspected of being a person with mental retardation or a developmental disability and who is receiving services in a facility regulated or operated by TDMHMR or TDHS needs a guardian of the person or estate, or both. This agreement is entered into pursuant to the provisions of the Human Resources Code §22.002(f), and is therefore not subject to the provisions of the Interagency Cooperation Act[, Chapter 771, Texas Government Code].

(b) Facilities. The agencies prescribe these as the facilities which must use the **capacity** assessment **tool:** [under the pilot described in subsection (e) of this section;]

(1) TDMHMR: residential services facilities (community-based residential services at community centers, state schools, state centers, and intermediate care facilities for **persons with mental retardation or related conditions** [the mentally retarded] **(ICFs-MR/RC)**[(ICFs-MR)]);

(2) TDHS: nursing facilities.

(c) Circumstances **of capacity assessment** . **In a residential services facility and a nursing facility, the** [The] capacity assessment tool will be administered to an elderly person, a person with mental retardation, a person with a developmental disability, which was not diagnosed as a result of the development of mental illness before age 22, or a person who is suspected of being a person with mental retardation or a developmental disability when incapacity is suspected **or reported.** [by:]

[(1) a representative of an interdisciplinary care plan team in nursing facilities; and

[(2) an interdisciplinary team (IDT) in residential services facilities;]

(d) Initiation of capacity assessment. A capacity assessment will be initiated when incapacity is suspected by or reported to:

(1) member(s) of the planning team at a residential services facility; and

(2) member(s) of the interdisciplinary care plan team at a nursing facility.

(e) Administration of capacity assessment. The capacity assessment will be administered by:

(1) the licensed or certified professional designated by the planning team at a residential services facility; and

(2) the social worker at a nursing facility, with optional assistance from member(s) of the interdisciplinary care plan team.

(f)[(d)] Focus of capacity assessment. The assessment tool will be used to assess the capacity of an identified person's ability to make decisions concerning the person's own welfare and financial affairs, including the person's:

(1) need for a guardianship and the type of guardianship that is appropriate for the person;

(2) ability to care for the person's own physical health or to manage the person's own financial affairs;

(3) ability to provide food, clothing, or shelter for himself or herself;

(4) decision-making ability; and

(5) ability to communicate a decision.

[(e) Administration. The agencies will pilot use of the uniform assessment tool as follows:

[(1) Duration. The agencies will pilot test the use of the uniform assessment tool between September 1, 1995 and August 31, 1996.

[(2) Location. The agencies will pilot test the uniform assessment tool at the following locations:

[(A) TDMHMR will implement in at least three facilities of varied sizes and staffing patterns; and

[(B) TDHS will implement in at least one county.

[(3) Staff. The following facility staff will administer the uniform assessment tool:

[(A) TDMHMR: the IDT will designate professional staff or team members at residential services facilities; and

[(B) TDHS: the social worker at a nursing facility.

[(4) Evaluation. During the pilot test, the agencies will evaluate the use of the uniform assessment tool and will make decisions regarding the continuation and expansion of use of the uniform assessment tool.]

(g) Agencies' administration of capacity assessment. Beginning September 1, 1996, the agencies will produce a report on the results of the capacity assessment pilot study, develop the final version of the capacity assessment tool and implement the use of the capacity assessment tool at residential services facilities and nursing facilities.

(h)[(f)] Annual review. No later than the last month of each state fiscal year, TDMHMR and TDHS shall review and modify the MOU as necessary.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701503
Glenn Scott
General Counsel, Legal Services
Texas Department of Human Services
Proposed date of adoption: April 1, 1997
For further information, please call: (512) 438–3765

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Chapter 90. Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions

Subchapter G. Abuse, Neglect, and Exploitation; Complaint and Incident Reports and Investigations

40 TAC §90.211, §90.212

The Texas Department of Human Services (DHS) proposes the repeal of §90.211 and §90.212 and new §90.211 and §90.212, concerning definitions and incidents of abuse and neglect, in its Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICF-MR/RC) chapter. The purpose of the repeals and new sections is to add definitions and to add procedures to be used when conducting an investigation in a private ICF-MR/RC facility.

Terry Trimble, interim commissioner, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Mr. Trimble also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be to provide the facility investigators with guidelines on conducting abuse and neglect investigations. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

Questions about the content of this proposal may be directed to Maxcine Tomlinson at (512) 438-3169 in DHS's Long Term Care Policy Section. Written comments on the proposal may be submitted to Supervisor, Rules Unit, Media and Policy Services-090, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714- 9030, within 30 days of publication in the *Texas Register*.

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Department of Human Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeals are proposed under the Health and Safety Code, Chapter 242, which provides the department with the authority to license intermediate care facilities serving persons with mental retardation or a related condition; and under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The repeals implement the Health and Safety Code, §§242.001 - 242.268, and the Human Resources Code, §§22.001-22.030.

§90.211. Definitions.

§90.212. Incidents of Abuse and Neglect Reportable by Facilities to the Texas Department of Human Services (DHS).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701374
Glenn Scott
General Counsel, Legal Services
Texas Department of Human Services
Proposed date of adoption: May 1, 1997
For further information, please call: (512) 438–3765

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The new sections are proposed under the Health and Safety Code, Chapter 242, which provides the department with the authority to license intermediate care facilities serving persons with mental retardation or a related condition; and under the Human Resources Code, Title 2, Chapter 22, which authorizes the department to administer public assistance programs.

The new sections implement the Health and Safety Code, §§242.001 - 242.268, and the Human Resources Code, §§22.001-22.030.

§90.211. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. For purposes of this subchapter, the terms "abuse" and "neglect" are understood to incorporate "abuse of a child" and "neglect of a child."

Abuse- Any of the following actions:

(A) any act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, which caused or may have caused physical injury or death to a person served;

(B) any act of inappropriate or excessive force or corporal punishment, regardless of whether the act results in an injury to a person served;

(C) any use of chemical or bodily restraints not in compliance with federal and state laws and regulations;

(D) sexual abuse as defined in this section; and

(E) any act or use of verbal or other communication including gestures to curse, vilify, or degrade a person served or threaten a person served with physical or emotional harm.

Abuse of a child - The following acts or omissions by any person:

(A) mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;

(B) causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;

(C) physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;

(D) failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;

(E) sexual conduct harmful to a child's mental, emotional, or physical welfare;

(F) failure to make a reasonable effort to prevent sexual conduct harmful to a child;

(G) compelling or encouraging the child to engage in sexual conduct as defined by the Texas Penal Code, §43.01; or

(H) causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene (as defined by the Texas Penal Code) or pornographic.

Child - A person under 18 years of age who is not and has not been married or who has not had the disabilities of minority removed for general purposes.

Class I abuse - Any act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, which caused or may have caused serious physical injury to a person served; or any sexual abuse involving an employee, agent, or contractor and a person served, without regard to injury.

Class II abuse- Any act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, which caused or may have caused nonserious physical injury to a person served; any act of force or corporal punishment, including striking or pushing a person served, regardless of whether the act results in nonserious injury to a person served; or exploitation.

Class III abuse- Any use of verbal or other communication to curse, vilify, or degrade a person served, or to threaten a person served with physical or emotional harm, or any act which vilifies, degrades, or threatens a person served with physical or emotional harm.

Complaint - An allegation of abuse, neglect, misappropriation of property, or any other allegation of a regulatory violation which is reported by residents, family members, or any other person.

Confirmed- A finding that an allegation of abuse, neglect, or exploitation is supported by the preponderance of the evidence.

Department - Texas Department of Human Services.

Exploitation - The illegal or improper act or process of using a person served or the resources of a person served for monetary or personal benefit, profit, or gain.

Facility- The management, administrator or other person involved in the provision of care and services to residents/clients, also including the physical building.

Frequency - The incidence or extent of the occurrence of an identified situation in the facility. The situation can affect a single resident or multiple residents.

Immediate and serious threat - A situation or set of circumstances in which a high probability exists that serious harm or injury to residents

could occur at any time or already has occurred and may occur again if residents are not protected from harm or the threat is not removed.

Incident - An allegation of abuse or neglect reported by facility staff to the Texas Department of Human Services state office as required by law.

Incitement - To spur to action or instigate into activity; implies responsibility for initiating another's actions.

Misappropriation of property - The taking, secretion (concealing), misapplication, deprivation, transfer or attempted transfer to any person not entitled to receive any property, real or personal, or any other thing of value belonging to or under the legal control of a resident without the effective consent of the resident or other appropriate legal authority or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.

Neglect- A negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused physical or emotional injury or death to an individual with mental illness or mental retardation which placed an individual with mental illness or mental retardation at risk of physical or emotional injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a person served, the failure to provide adequate nutrition, clothing, or health care to a person served, or the failure to provide a safe environment for a person served, including the failure to maintain adequate numbers of appropriately trained staff.

Neglect of a child - Any of the following:

(A) an act which leaves a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and a demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of a child;

(B) the failure by the person responsible for a child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away; or

(C) the following acts or omissions by any person:

(i) placing a child in or failing to remove the child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child;

(ii) the failure to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child;

(iii) the failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability unless relief services had been offered and refused; or

(iv) placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child.

Nonserious physical injury- Any injury determined not to be serious by the examining physician. Examples of nonserious injury may include the following: superficial laceration, contusion, abrasion.

Person responsible for a child's care, custody, or welfare - A person who traditionally is responsible for a child's care, custody, or welfare, including:

(A) a parent, guardian, managing or possessory conservator, or foster parent of the child;

(B) a member of the child's family or household as defined by the Texas Family Code, Chapter 71;

(C) a person with whom the child's parent cohabits;

(D) school personnel or a volunteer at the child's school; or

(E) personnel or a volunteer at a public or private child-care facility that provides services for the child or at a public or private residential institution or facility where the child resides.

Perpetrator - The person who has committed an act of abuse, neglect, or exploitation.

Potential for harm - An observed facility practice that is so divergent from accepted standards of practice that future negative outcome or harm is probable.

Provider - An individual or legal business entity contractually responsible for providing services.

Reporter - The person filing a report of alleged abuse, neglect, or exploitation, whether the victim of alleged abuse, neglect or exploitation, a third party filing a report on behalf of the alleged victim, or both.

Resident- An individual including a patient or client who receives treatment, care, or services from a provider.

Serious physical injury - An injury determined to be serious by the examining physician. Examples of serious injury may include the following: fracture, dislocation of any joint, internal injury, any contusion larger than two and one half inch in diameter, concussion, second or third degree burns.

Severity- The seriousness of the identified situation; the degree to which a problem compromises residents' health and safety, or fails to achieve the highest practicable level of physical, mental and psychosocial well-being.

Sexual abuse - Any sexual activity, including sexual exploitation as defined in the Texas Penal Code, involving an employee, agent, or contractor and a person served. Sexual activity includes, but is not limited to, kissing with sexual intent, hugging with sexual intent, stroking with sexual intent, or fondling with sexual intent; oral sex or sexual intercourse; request or suggestion or encouragement by staff for performance of sex with the employee himself/herself or with another person served.

Sexual exploitation- A coercive, manipulative, or otherwise exploitative pattern, practice, or scheme of conduct, which may include sexual contact, that can reasonably be construed as being for the purposes of sexual arousal or gratification or sexual abuse of any person. The

term does not include obtaining information about a patient's sexual history within standard accepted clinical practice.

Sexually transmitted disease - Any infection of a person served, with or without symptoms or clinical manifestations, that is or may be transmitted from one person to another as a result of sexual contact between persons.

Unconfirmed - Term used to describe an allegation of abuse, neglect or exploitation which is not supported by the preponderance of the evidence.

Unfounded - A finding that an allegation of abuse, neglect or exploitation is spurious or patently without factual basis.

§90.212. Incidents of Abuse and Neglect Investigated and Reported by Facilities to the Texas Department of Human Services (DHS).

(a) Purpose; duty of facility to investigate. The purpose of the chapter is to define and prohibit abuse, neglect, and exploitation of any person receiving services from a facility licensed as an Intermediate Care Facility for Persons with Mental Retardation or Related Conditions under the Health and Safety Code, Chapter 242, or facility contractor; and to prescribe procedures that a facility must use in reporting abuse, neglect, and exploitation in conducting its own investigations and in training provided on conducting investigations. The facility must investigate reports of abuse, neglect, and exploitation.

(b) Reporting responsibilities of employees; failure to report.

(1) Each employee who suspects or has knowledge of, or who is involved in an allegation of abuse, neglect, or exploitation, shall make a verbal report to the facility administrator or designated authority immediately, if possible, but in no case more than one hour after the incident.

(2) If the person making the allegation is not an employee, such as a person receiving services or a guest, staff shall assist the individual in making the report, if necessary.

(3) The facility owner, designated authority, administrator, or employee of the facility who has cause to believe that the physical or mental health or welfare of a resident has been, or may be adversely affected by abuse or neglect caused by another person, must report the abuse or neglect to the Texas Department of Human Services (DHS), at 1-800-292- 2065, any day or hour. The following incidents must be reported to DHS's state office, regardless of the time of day: death; missing resident; abuse or neglect allegations; sexual abuse; misappropriation of resident property; accidental injuries or injuries of unknown origin, if there is reason to believe they were the result of abuse or neglect or if they resulted in serious physical injury; and resident-to-resident abuse if a resident is killed, taken to the hospital, or the physician has ordered treatment other than observation when there is a serious injury.

(4) Failure to report abuse and/or neglect to the administrator or designated authority immediately, but in no case after more than one hour, without sufficient justification or an employee who made a false statement of fact during an abuse investigation shall be considered in violation of this chapter.

(c) Qualifications of the facility investigator.

(1) The investigator may be an employee of the licensed facility or an independent party who has been trained by an organization that specializes in procedures and techniques for the investigation of abuse and neglect.

(2) The investigator cannot be the alleged perpetrator or involved in the allegation of abuse or neglect.

(3) The investigator must receive and provide evidence, upon request, that he received training on investigation procedures. The documentation must be maintained in the facility files.

(d) Responsibility of the facility investigator.

(1) Within 24 hours of receipt of an allegation, the investigator will begin to conduct an investigation. The investigator will:

(A) immediately notify the law enforcement agency of any sexual incident, physical abuse that results in an injury, drug diversions, burglary, and theft, for investigation and evidence collection. The investigator will record the date and time of the allegation, name of law enforcement employee contacted, and the police case number;

(B) interview all witnesses, the alleged victim, and the alleged perpetrator as soon as possible after the initial report of the allegation;

(C) obtain a written and signed statement regarding the allegation following each interview. The statement(s) may be written by the investigator, but shall be signed and dated by those giving the statement and by the investigator;

(D) ensure that appropriate medical treatment was obtained, if warranted, for the alleged victim and the treatment was documented; and

(E) review and evaluate all physical, circumstantial and direct evidence, in order to determine whether there is sufficient evidence to confirm the allegation, through:

(i) interviews;

(ii) statements;

(iii) physical exam and medical treatment rendered;

(iv) photographs;

(v) diagrams;

(vi) visits to the site of the incident;

(vii) other physical evidence; and

(viii) use experts or consultants as needed.

(2) The investigator will write a report and it will contain the following information:

(A) a brief description of the allegation;

(B) a detailed description of the investigation from its initiation to completion, including date, time and location of the alleged incident; location of the alleged victim, witnesses, and the suspect; description of injuries to the alleged victim; how the incident was discovered; how the alleged perpetrator was identified; description of any other evidence; and how the evidence was collected and protected;

(C) summary of the evidence;

(D) analysis of the evidence;

(E) determination as to whether the abuse, neglect or exploitation occurred;

(F) classification of the incident, as defined in §90.211 of this title (relating to (Definitions); and

(G) recommendations regarding corrective actions.

(3) The report should include all witness statements and supporting documentation.

(4) The investigator will provide a copy of the report to the facility administrator or designated authority.

(5) The administrator or designated authority will accept or reject the recommendations and document justification in areas of disagreement, which will be attached to the facility investigator's report.

(6) The written investigation report must be sent to DHS no later than the fifth calendar day after the oral report.

(7) The facility will also send the written investigation report to DHS.

(8) If law enforcement was notified, the investigator or administrator or designated authority will submit the report to the law enforcement agency.

(e) Responsibilities of the facility administrator or designated authority.

(1) Immediately, but in no case more than one hour, after notification of an allegation of abuse, neglect, or exploitation, the facility administrator or designated authority shall ensure that adequate medical and psychological care have been provided to the alleged victim, and shall take measures to ensure the safety of the person, including the following actions.

(A) If the accused is an employee, including a contracted provider of service, the facility administrator or designated authority will determine whether action should be taken regarding the employee, which could include termination of employment, reassigning the employee to non-client contact, or granting the employee leave pending an investigation. An employee accused of client abuse should be immediately separated from contact with residents.

(B) If a resident has been involved in an aggressive action, the facility administrator or designated authority will take immediate appropriate action to protect the alleged victim and other residents, such as one-on-one observation of the alleged perpetrator or the alleged victim, or separation.

(C) If the accused is another person who is known but who is neither a staff person or resident, such as a family member or friend, the facility interdisciplinary team (IDT) and client will address the alleged perpetrator's access to the alleged victim pending an investigation. The restriction and justification shall be documented in the resident's record. The facility administrator or designated authority will contact the Texas Department of Protective and Regulatory Services at 1-800-252-5400 for investigation, in addition to notifying DHS.

(D) The facility administrator or designated authority, with the consent of the alleged victim or his legal guardian, shall immediately, but in no case later than 24 hours after notification of an allegation of abuse, neglect or exploitation, notify the parents, spouse, or other appropriate relative of the alleged victim. If oral contact cannot be made, the administrator will provide notification by certified mail with a return receipt requested.

(E) The facility administrator or designated authority will ensure that the resident's medical and psychological needs are met immediately and on an ongoing basis.

(2) The facility administrator or designated authority will notify the facility investigator immediately, but in no case more than one hour after notification of the incident, of the alleged abuse, neglect, or exploitation.

(3) The facility administrator or designated authority will assist the investigator in whatever way possible to make staff who are relevant to the investigation available in an expeditious manner and ensure all evidence is preserved and safe guarded to protect the chain of evidence.

(f) Confidentiality of the investigative process.

(1) The reports, records, and working papers used by or developed in the investigative process and the resulting final report regarding abuse, neglect, and exploitation are confidential and may be disclosed only as provided under law.

(2) The administrator or designated authority will advise the resident of the outcome in a language or process which the resident understands and in writing. The legal guardian or parent of a minor and reporter(s) shall be informed in writing of the outcome of the investigation.

(3) The perpetrator will be informed of the outcome of the investigation and any disciplinary action.

(g) Facility responsibility.

(1) The facility administrator or designated authority must ensure that resident rights and protection are upheld at all times.

(2) If resident-to-resident abuse is substantiated, the facility IDT will determine if the victim understands the situation and is able to make informed decisions. If the IDT determines that the victim is unable to make informed decisions, the IDT will determine if the perpetrator's behavior is dangerous and ongoing. If it is determined that the behavior is dangerous and ongoing, the facility will take immediate action to protect all residents in the facility. In addition, the IDT will consider program changes and/or discharge planning for the perpetrator. If the behavior of the perpetrator is not dangerous and ongoing, the IDT will determine what the needs of the perpetrator are, such as behavior program or specialized training, and take appropriate action.

(3) If abuse by an outside person, not facility or contract staff, is substantiated, the facility IDT will determine if the victim is able to make an informed decision regarding any interaction with the perpetrator. If the IDT determines that the client is unable to make informed decisions, the IDT will determine the degree of restrictions on visitation.

(h) Disciplinary action.

(1) The facility administrator or designated authority will be responsible for taking prompt and proper disciplinary action when a charge of abuse, neglect, or exploitation is confirmed by the investigator.

(2) If a provider continues to employ an employee who has a pattern of abuse, neglect, or exploitation, DHS may impose a sanction of license revocation, denial of license renewal, or civil penalties under Health and Safety Code §242.065.

(3) If anyone is dissatisfied with the investigation, they may contact DHS.

(i) Failure to report. Failure to report and/or conduct investigations in accordance with this section may result in license revocation, denial of license renewal, or civil penalties under Health and Safety Code, §242.065.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701373
Glenn Scott
General Counsel, Legal Services
Texas Department of Human Services
Proposed date of adoption: May 1, 1997
For further information, please call: (512) 438–3765

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TITLE 43. TRANSPORTATION

Part I. Texas Department of Transportation

Chapter 2. Environmental Policy

Subchapter C. Environmental Review and Public Involvement for Transportation Projects

43 TAC §2.41, §2.45

The Texas Department of Transportation proposes amendments to §2.41, concerning Definitions, and §2.45, concerning Gulf Intracoastal Waterway Projects.

Transportation Code, Chapter 51, charges the commission, through the department, with the responsibility of administering the state's nonfederal sponsorship of the Gulf Intracoastal Waterway, including coordination with the U.S. Army Corps of Engineers for matters relating to the operation and maintenance of the Gulf Intracoastal Waterway. House Bill 1536, 74th Legislature, 1995, amended Chapter 51 of the Transportation Code to allow the commission, through the department, to enter into agreements with the Department of the Army to participate in the cost of projects to beneficially use material dredged from the Gulf Intracoastal Waterway. House Bill 1536 directed the commission to adopt rules establishing eligibility criteria for proposed beneficial use projects.

Section 2.41 is amended to provide a definition for beneficial use projects and amends the definition of the Gulf Intracoastal Waterway Advisory Committee to add a provision concerning beneficial use projects.

Section 2.45 is amended to specify that the department is authorized to participate in beneficial use projects for material dredged from the Gulf Intracoastal Waterway; to include beneficial use projects in the environmental review and public involvement requirements of Gulf Intracoastal Waterway projects; to specify broad use categories in which the department will participate in beneficial use projects; to specify the information required to be sent in a proposal from the U.S. Army Corps of Engineers for a proposed beneficial use project; to specify that if a proposed beneficial use project requires the acquisition of an interest in property, the commission will conduct a public hearing on the desirability of the project before authorizing participation; to specify the criteria for the commission's approval of department participation in a beneficial use project, including the statutory requirements that the project can be accomplished without unjustifiable waste of publicly or privately owned natural resources and without permanent substantial adverse impact on the environment, wildlife, or fisheries; and to specify the extent of the department's financial participation in a beneficial use project. The section as amended is consistent with the Texas Coastal Management Program goal of protecting, preserving, restoring, and enhancing coastal natural resource areas as material dredged from the Gulf Intracoastal Waterway may be beneficially used for purposes such as beach nourishment, shoreline stabilization and erosion control, and habitat development. The amended section is also consistent with the Coastal Management Program policy of requiring information necessary to make an informed decision on a proposed action subject to the Coastal Management Program and the policy of using dredged material from dredging projects in commercially navigable waterways beneficially. The section requires the U.S. Army Corps of Engineers to submit proposals for beneficial use projects for material they dredge from the Gulf Intracoastal Waterway which include a description of the proposed project and its anticipated benefits, a detailed estimate of project cost, and a plan addressing the operation and maintenance of the facility created by or benefiting from the project.

Frank J. Smith, Director, Budget and Finance Division, has determined that for each year of the first five-year period the amendments are in effect there will be fiscal implications for state government as a result of enforcing or administering the amendments. The estimated additional costs for state government are $251,650 in fiscal year 1997; $301,418.68 in fiscal year 1998; and $427,243.68 each year in fiscal years 1999, 2000, and 2001. There are anticipated fiscal implications for local governments as a result of enforcing or administering the amendments. However, these costs cannot be quantified as participation is voluntary and costs may vary depending on the number of local governments which choose to participate in a beneficial use project, the extent of participation, and the number and types of projects participated in. Also. the anticipated economic costs to persons who are required to comply with the rules as proposed, cannot be quantified for the same reasons as stated for local governments.

James L. Randall, Director, Multimodal Operations Office, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amended sections.

Mr. Randall has also determined that for each year of the first five years the amended sections are in effect the public benefit anticipated as a result of enforcing the sections will be: to

provide for a safe, efficient, and environmentally sound transportation system, particularly the Gulf Intracoastal Waterway, a crucial component of the state's multimodal transportation system; to provide for the use of material dredged from the Gulf Intracoastal Waterway for purposes which benefit the public; and to be consistent with the goals and policies of the Texas Coastal Management Program. There will be no effect on small businesses.

Pursuant to the Administrative Procedure Act, the Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed amended sections. The public hearing will be held at 9:00 a.m. on Tuesday, February 25, 1997, in the first floor hearing room of the Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas, and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 8:30 a.m. Any interested person may appear and offer comments, either orally or in writing, however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views, and same or similar comments, through a representative member where possible. Presentations must remain pertinent to the issue being discussed. A person may not assign a portion of his or her time to another speaker. A person who disrupts a public hearing must leave the hearing room if ordered to do so by the presiding officer. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or braille, are requested to contact Eloise Lundgren, Director of the Public Information Office, at 125 East 11th Street, Austin, Texas, 78701-2483, (512) 463-8588 at least two working days prior to the meeting so that appropriate arrangement can be made.

Written comments on the proposed amendments may be submitted to James L. Randall, Director, Multimodal Operations Office, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701. The deadline for receipt of written comments will be at 5:00 p.m. on March 17, 1997. Comments are specifically requested on the consistency of the proposed amended sections with the Texas Coastal Management Act.

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to promulgate rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, Chapter 51, which authorizes the commission to enter into agreements with the Department of the Army to participate in the cost of projects to beneficially use material dredged from the Gulf Intracoastal Waterway and directs the commission to adopt rules establishing the eligibility criteria for proposed beneficial use projects. The amendments are subject to the Texas Coastal Management Program and must be consistent with all applicable Coastal Management Program policies.

No other statutes, articles, or codes are affected by the proposed amendments.

§2.41. Definitions.

The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

Beneficial use project - The productive and positive use of dredged material as proposed by the United States Army Corps of Engineers.

Gulf Intracoastal Waterway Advisory Committee (GIWAC) - An interagency committee, made of members appointed by the department to represent state agencies having jurisdiction in the protection of the state's natural, historic, and economic resources. The GIWAC is created for the purpose of advising and assisting the department:

(A) (No change.)

(B) in developing proposals for **a** [an optimum] disposal plan **or a beneficial use project** that will address dredged material disposal **involving a segment of the GIWW identified by the U.S. Army Corps of Engineers as in need of maintenance dredging** [in an identified area of need]; and

(C) (No change.)

§2.45. Gulf Intracoastal Waterway Projects.

(a) Non-federal sponsorship. The commission, pursuant to **Transportation Code, Chapter 51** [Texas Civil Statutes, Article 5415e-2], is charged with the responsibility of administering the state's nonfederal sponsorship of the Gulf Intracoastal Waterway (GIWW), including coordination with the U.S. Army Corps of Engineers, all other appropriate federal and state agencies, navigation districts and port authorities, counties, and other appropriate persons [to determine specifically what must be done by the state to satisfy requirements relating to the nonfederal sponsorship of the GIWW in a manner consistent with the policy of the state, as described in Texas Civil Statutes, Article 5415e-2].

(b) Disposal of dredged material.

(1) Disposal plan. The department may participate in the development of a disposal plan for dredged material.

(2) Beneficial use project. The department may participate in the development of a beneficial use project for dredged material.

(A) Proposals. The department will accept from the U.S. Army Corps of Engineers proposals for beneficial use projects in the following broad use categories:

(i) **habitat development;**

(ii) **beach nourishment;**

(iii) **aquaculture;**

(iv) **parks and recreation;**

(v) **agriculture, forestry and horticulture;**

(vi) **strip mine reclamation and solid waste management;**

(vii) **shoreline stabilization and erosion control;**

(viii) **construction and industrial use;**

(ix) **material transfer (fill, dikes, levees, parking lots, roads); and**

(x) **multiple purposes (the combination of categories on a single dredging project).**

(B) Submittal of proposals. The U.S. Army Corps of Engineers shall submit proposals in writing to the executive director or his or her designee. The proposals shall include:

(i) **a description of the proposed beneficial use project and anticipated benefits;**

(ii) **a map delineating the location or locations of the proposed beneficial use project;**

(iii) **a proposed project schedule including an anticipated completion date;**

(iv) **a detailed estimate of the project cost, including an estimate of the U.S. Army Corps of Engineers' financial contributions to the project; and**

(v) **a plan addressing the operation and maintenance of the facility created by or benefitting from the beneficial use project.**

(c)[(b)] Early coordination. Early coordination with appropriate state and federal agencies will be conducted by the department to develop a proposal for **a** [an optimum] disposal plan **or a beneficial use project involving a segment of the GIWW identified by the U.S. Army Corps of Engineers as in need of maintenance dredging** [in an identified area of need]. Any proposed plan shall address the dredged material disposal needs of maintaining the GIWW in Texas. The department is responsible for initiating and overseeing early coordination.

(d)[(c)] Investigation of disposal alternatives.

(1) The department will appoint a task force of the GIWAC to investigate disposal alternatives **and beneficial use projects involving a segment of the GIWW identified by the U.S. Army Corps of Engineers as in need of maintenance dredging** [in the identified area of need] and **evaluate** [ascertain] the environmental and operational suitability of each. The task force will include representatives from state and federal agencies having jurisdiction in the protection of the state's natural, historic, and economic resources.

(2) The department will lead any field investigations. The task force agencies will be requested to participate in field investigations and to provide to the department written evaluations of the disposal alternatives **and beneficial use projects** investigated.

(3) The GIWAC will review the investigations and discuss **with the department** any proposed [optimum] disposal plans **or beneficial use projects** [for the identified area of need with the department].

(4) After review by the GIWAC, the department will notify the governing bodies of any city or county with jurisdiction over a proposed project area of a proposed beneficial use project. The department will provide the governing bodies a description of the proposed project and anticipated benefits and will request that the governing bodies provide an adopted resolution or other official document if the governing body supports the proposed project.

(e)[(d)] Federal coordination.

(1) After review by the GIWAC, the department will request the U.S. Army Corps of Engineers to coordinate the environmental analysis pursuant to 42 United States Code §§4321 et seq.

(2) If the U.S. Army Corps of Engineers' environmental analysis determines a finding of no significant impact for the proposed disposal plan **or beneficial use project**, the division will then review the environmental document and findings. If the division determines that the proposed disposal plan **or beneficial use project** can be accomplished in an environmentally acceptable manner, the department will then proceed with public involvement.

(f)[(e)] Public involvement.

[(1)] Public involvement will be accomplished primarily through the U.S. Army Corps of Engineers' environmental and public involvement procedures; however, the department will conduct its own public involvement process.

(1) Preliminary involvement.

(A) The department will notify a landowner of a parcel's environmental and operational suitability for the proposed disposal plan **or beneficial use project**, and offer to meet with the landowner to answer any questions about the proposed disposal plan **or beneficial use project**.

(B) The department will also notify the landowner of any public meeting or public hearing on the proposed disposal plan **or beneficial use project**.

(C) Meetings, as one form of public involvement, with affected property owners and residents will be held [under the following conditions, and] pursuant to §2.43(b)(2)(A) of this title (relating to Highway Construction Projects - State Funds)**,** [:]

[(i)] when the proposed disposal plan **or beneficial use project** does not involve any adjacent landowners **or** [; and]

[(ii)when] the landowner requests a meeting.

(D) Public meetings, as another form of public involvement may be held pursuant to §2.43(b)(2)(B) of this title (relating to Highway Construction Projects - State Funds).

(2) Public Meetings. A notice of public meeting [Public meetings] will be advertised through legal notices published once a week for three successive weeks in a newspaper of general circulation, published in the county seat of each county in which any such proposed dredged material disposal plan **or beneficial use project** is located.

(3) Public Hearings. [(E)] A public hearing**, when required,** will be conducted by the commission **pursuant to Transportation Code, Chapter 51** [as required by Texas Civil Statutes, Article 5415e-2]. **A hearing is required under Transportation Code, Chapter 51 if a disposal plan or beneficial use project requires the acquisition of an interest in property.**

(A)[(i)] Prior to the hearing, the commission shall publish notice of a public hearing, indicating date, time, and place of such hearing, at least once a week for three successive weeks in a newspaper of general circulation published in the county seat of each

county in which any such proposed dredged material disposal plan **or beneficial use project** is located.

(B)[(ii)] The commission shall also publish notice of such hearing in at least one edition of the Texas Register.

(C)[(iii)] The U.S. Army Corps of Engineers' environmental documents and findings will be on display at the public hearing.

(D)[(iv)] Comments, testimony, or evidence shall be given in person or in writing during the public hearing or may be submitted in writing to the commission during the prescribed public comment period.

(g)[(f)] Commission action.

(1) Disposal plans.

(A)[(1)] After the public hearing and receipt of all evidence and testimony, the commission will determine whether such proposed dredged material disposal plan can be accomplished without unjustifiable waste of publicly or privately owned natural resources and without permanent substantial adverse impact on the environment, wildlife, or fisheries.

(B) [(2)] If the commission determines that the proposed plan meets the criteria described in **subparagraph**

(A) [paragraph (1)] of this **paragraph** [subsection], it will authorize the department to proceed with the necessary actions to accomplish the disposal plan.

(2) Beneficial use projects.

(A) Approval. After any required public involvement, and receipt of all evidence and testimony, the commission will approve department participation in a beneficial use project provided funds are available for such purpose, the applicable requirements of NEPA have been satisfied by the U.S. Army Corps of Engineers, and the project:

(i) **is proposed by the U.S. Army Corps of Engineers;**

(ii) **proposes one or more beneficial use activities having a direct relationship of function or impact to the GIWW;**

(iii) **can be accomplished without permanent substantial adverse impact on the environment, wildlife, or fisheries;**

(iv) **represents a prudent and justifiable use of publicly or privately owned resources;**

(v) **has substantial local support, as evidenced through the public involvement process and documentation such as the adoption of a resolution or other official document from at least one of the governing bodies of any city or county with jurisdiction over the project area;**

(vi) **is limited to a logical unit of work and is capable of being implemented and completed within a reasonable time as determined by the department; and**

(vii) **is consistent with the Texas Coastal Management Program.**

(B) Financial participation.

(i) **Except as provided in clause (ii) of this subparagraph, the commission will establish an eligible cost of the proposed beneficial use project by calculating the total estimated cost of the project in excess of the established federal standard for dredged material disposal. The department's financial participation in the project will not exceed 50% of eligible cost (up to a maximum of $125,000 per beneficial use project).**

(ii) **The commission may authorize participation at levels exceeding 50% (and/or $125,000) if the commission determines the additional participation will result in extraordinary environmental or economic benefits or the costs are reasonably comparable to the costs of providing property to accommodate traditional upland disposal.**

(iii) **If approved under this paragraph the commission will enter into an agreement with the Department of the Army to participate in the cost of a project to beneficially use material dredged from the GIWW.**

(iv) **Department funding shall not be used for maintenance or operation of a beneficial use project.**

(v) **All project expenditures must conform to applicable provisions of state and federal law.**

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701495
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 14, 1997
For further information, please call: (512) 463-8630

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Chapter 9. Contract Management

Subchapter D. Business Opportunity Programs

43 TAC §§9.50-9.61

The Texas Department of Transportation proposes new §§9.50-9.61, concerning the department's business opportunity programs.

Government Code, Chapter 2161, Transportation Code, §201.702, and Title 49, Code of Federal Regulations, Part 23, provide for a Disadvantaged Business Enterprise (DBE) Program on contracts that are funded in whole or in part with federal funds, and for a Historically Underutilized Business (HUB) Program for contracts that are funded entirely with state or local funds. Section 9.50 explains that the purpose of the subchapter is to establish policies and procedures implementing the department's DBE and HUB programs and for resolving complaints relating to these programs.

Section 9.51 defines words and terms used in this subchapter.

Section 9.52 provides that it is the department's policy to ensure that DBEs and HUBs have the maximum opportunity to participate in the performance of contracts and subcontracts

and to prohibit discrimination on the basis of race color, national origin, or gender in the award and performance of contracts.

Section 9.53 explains which contracts and purchases the DBE and HUB programs apply to.

Section 9.54 provides that the department will establish DBE and HUB goals, and describes the procedures for establishing annual goals and the criteria for assigning participation goals for individual contracts.

Section 9.55 provides that the department will make a good faith effort to meet or exceed the annual DBE/HUB goals, requires that the contractor document the efforts taken in good faith to obtain DBE/HUB participation, and specifies the types of efforts the department will consider as evidence of good faith attempts to obtain DBE/HUB participation.

Section 9.56 describes the department's procedures for certifying a firm as a DBE, including specific standards used for certification. This section also outlines various certification categories of businesses/owners, on-site review of businesses for certification purposes, certification renewal procedures, steps for third-party actions, and procedures for requesting an eligibility conference. Section 9.56 also provides that the department will maintain a directory of certified DBEs.

Section 9.57 provides that the General Services Commission (GSC) certifies businesses as HUBs and references GSC certification procedures. This section also specifies that the department will submit information regarding DBEs who qualify as HUBs to GSC for certification and recognizes that GSC maintains a directory of certified HUBs.

Section 9.58 provides for DBE/HUB contract provisions, including program requirements for contracts with an assigned goal, and specifies that a contract without a goal will include a provision encouraging the use of DBEs and HUBs. This section provides for department monitoring of contractor compliance, requires DBE/HUB commitments and reports, and provides for credit of certain contractor expenditures. It specifies the type of function a DBE/HUB must perform, establishes the percentage a DBE/HUB contractor or subcontractor may subcontract, prohibits a contractor from furnishing work crews or equipment to a DBE/HUB without prior authorization from the department, and requires that the contractor not create unnecessary barriers to DBE/HUB performance. This section also specifies when a contractor may substitute a DBE/HUB firm originally authorized, the retention period for contractor records, a process for the contractor to respond to a finding of noncompliance with DBE/HUB contract provisions, and sanctions for noncompliance. This section permits a contractor to appeal a sanction to the Business Appeals committee.

Section 9.59 provides for filing a complaint related to a federally funded contract with the U.S. Department of Transportation in certain circumstances, provides that a claim by a prime contractor for additional compensation or time extension will be heard in accordance with §9.2, provides a complaint process for a Bidder/Proposer that was not selected for a department contract, establishes a complaint process for an aggrieved firm or person who believes that the person or firm, another person, or any specific class of individuals to be subject to a violation of the DBE/HUB program, and provides that if a bidder/proposer or a complainant is not satisfied with the department response, the aggrieved party may request an investigation or file an appeal with the U.S. Department of Transportation.

Section 9.60 specifies the procedures by which the department will investigate a complaint filed by a person or business aggrieved by a finding, response, or determination resulting from any protest, complaint or dispute under §9.59 of this title (relating to Business Complaints). This section also provides for an appeal of the final determination to the Business Appeal Committee (BAC) in certain circumstances.

Section 9.61 specifies in what circumstances a third party or firm may file an appeal with the U. S. Department of Transportation, specifies the requirements of any appeal, and provides that the U. S. Department of Transportation appeal process is final. This section also provides that the BAC will hear certain appeals relating to sanctions and contract complaints pursuant to §§9.58-9.59.

Frank J. Smith, Director, Budget and Finance Division, has determined that for the first five years the sections are in effect, there will be fiscal implications to the state as a result of enforcing or administering the sections. The anticipated estimated increase in cost to the state is $1,595, 212 for Fiscal Year 1997, $1,627,117 for Fiscal Year 1998, $1,659,657 for Fiscal Year 1999, $1,692,849 for Fiscal Year 2000, and $1,726,705 for Fiscal year 2001. There are no anticipated fiscal implications for local governments as a result of enforcing or administering the sections.

There is no anticipated economic cost to persons who are required to comply with the rules as proposed.

James Dossett, Director of the Business Opportunity Programs Office, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the new sections.

Mr. Dossett has also determined that for each year of the first five years the new sections are in effect the public benefit anticipated as a result of enforcing the sections will be the increased participation of minority and women-owned small businesses in the contracting activities of the department and a complaint process for businesses to voice their concerns regarding department business practices. There will be no effect on small businesses.

Pursuant to the Administrative Procedure Act, the Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed sections. The public hearing will be held at 1:00 p.m. on Tuesday, February 25, 1997, in the first floor hearing room of the Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas, and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 12:30 p.m. Any interested person may appear and offer comments, either orally or in writing, however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time

and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views, and same or similar comments, through a representative member where possible. Presentations must remain pertinent to the issue being discussed. A person may not assign a portion of his or her time to another speaker. A person who disrupts a public hearing must leave the hearing room if ordered to do so by the presiding officer. Persons with disabilities who have special communication or accommodation needs and who plan to attend the hearing and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or braille, are requested to contact Eloise Lundgren, Director of the Public Information office, at 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-8588 at least two working days prior to the hearing so that appropriate arrangements can be made.

Written comments on the proposed new sections may be submitted to James Dossett, Director of the Business Opportunity Programs Office, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of written comments will be at 5:00 p.m. on March 17, 1997.

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to promulgate rules for the conduct of the work of the Texas Department of Transportation; Government Code, Chapter 2161, which provides for a Historically Underutilized Business Program for contracts that are funded entirely with state funds; and Transportation Code, §201.702, which provides for a Disadvantaged Business Enterprise Program.

No statutes, articles, or codes are affected by the proposed new sections.

§9.50. Purpose.

This subchapter establishes policies and procedures to implement the department's Disadvantaged Business Enterprise (DBE) and Historically Underutilized Business (HUB) programs in compliance with Transportation Code, §201.702; Government Code, Chapter 2161; and Title 49, Code of Federal Regulations, Part 23. This subchapter also establishes policies and procedures for resolving business complaints concerning the DBE/HUB programs.

§9.51. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

SBA 8(a) certification - The U.S. Small Business Administration's (SBA) certification of a small business as socially and economically disadvantaged pursuant to Section 8(a) of the Small Business Act, 15 United States Code, Chapters 631-656.

Affiliate - Concerns are affiliates of each other when, either directly or indirectly one concern controls or has the power to control the other, a third party or parties control or has the power to control both, or an "identity of interest" between or among parties exists such that affiliation may be found. In determining whether affiliation exists, the department will consider all appropriate factors, including common ownership, common management, sharing of services and facilities, and contractual relationships.

Bidder - An individual, partnership, limited liability company, corporation, joint venture or any combination that submits a bid for a contract advertised by the department. Broker - An intermediary or middleman who does not take possession of a commodity, does not act as a regular dealer selling to the public, or procures a service that is provided by another.

Business appeal committee (BAC) - A department committee appointed by the executive director to allow an aggrieved party an opportunity to rebut the findings of a formal investigation or sanction.

Business opportunity programs office (BOP) - The department office that certifies DBEs and administers the DBE and HUB programs.

Clearinghouse list - The DBE directory's list of organizations that provide assistance in the recruitment and placement of DBEs for the purpose of linking contractors with minority subcontractors.

Commission - The Texas Transportation Commission.

Concern - A business entity organized for profit, with a place of business located in the United States and which makes a significant contribution to the U.S. economy through payment of taxes and/or use of American products, materials and/or labor.

DBE certification - The process governed by 49 CFR Part 23 which verifies an applicant's eligibility to be a DBE.

DBE/HUB participation goal - A number representing participation in contracts and purchasing by a DBE/HUB firm determined by a percentage of the total cost of the contract or purchase.

Department - The Texas Department of Transportation.

DED - Deputy Executive Director of Administrative Services.

Disadvantaged Business Enterprise (DBE) - As defined in 49 CFR §23.62, a small business concern which is at least 51% owned by one or more socially and economically disadvantaged individuals, or in the case of a publicly owned business, at least 51% of the stock of which is owned by one or more socially and economically disadvantaged individuals, and whose management and daily business operations are controlled by one or more of the socially and economically disadvantaged individuals who own it.

Federal aid contract - A contract between the department and a contractor that is paid for in whole or in part with U.S. Department of Transportation or other federal financial assistance.

GSC - General Services Commission.

Highway improvement contract - A contract awarded by the commission under Transportation Code, Chapter 223.

Historically Underutilized Business (HUB) - Any business so certified by the General Services Commission.

Joint venture - An association of two or more businesses to carry out a single business enterprise for profit which combines their property, capital, efforts, skills, and knowledge.

Liquidated damages - Project-related damages to the department's DBE/HUB programs separate from those costs associated with construction engineering costs.

Maximum opportunity - The opportunity to bid and receive contracts and to perform those contracts without unnecessary barriers which could jeopardize successful completion.

Minority - As defined by 49 CFR §23.5, a person who is a citizen or lawful permanent resident of the United States and who is:

(A) Black (a person having origins in any of the black racial groups of Africa);

(B) Hispanic (a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race);

(C) Portuguese (a person of Portuguese, Brazilian, or other Portuguese culture or origin, regardless of race);

(D) Asian American (a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands);

(E) American Indian and Alaskan Native (a person having origins in any of the original peoples of North America); or

(F) members of other groups, or other individuals, found to be economically and socially disadvantaged by the Small Business Administration pursuant to Title 15, United States Code, §637(a).

Packager - A person or firm engaged in the commercial packing of materials or supplies produced by others.

Proposer - An individual, partnership, limited liability company, corporation, or any combination that submits a proposal for a contract advertised by the department.

Small business concern - A small business as defined in the Small Business Act, codified in 15 U.S.C. §632, and related regulations.

Socially and economically disadvantaged individuals - As defined in 49 CFR §23.62, individuals who are United States citizens (or lawfully admitted permanent residents) and who are Women, Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans, Asian-Indian Americans, or any other minorities or individuals found to be disadvantaged pursuant to SBA 8(a). There is a rebuttable presumption that individuals in the following groups are socially and economically disadvantaged:

(A) Black Americans which includes persons having origins in any of the Black racial groups of Africa;

(B) Hispanic Americans which includes persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish or Portuguese culture or origin, regardless of race;

(C) Native Americans which includes persons who are American Indian, Eskimo, Aleut, or native Hawaiian;

(D) Asian-Pacific Americans which includes persons whose origins are from Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, Philippines, Samoa, Guam, the Northern Marianas or the U.S. Pacific Trust Territories; or

(E) Asian-Indian Americans which includes persons whose origins are from India, Pakistan, or Bangladesh; or

(F) women.

Subcontractor - An individual, partnership, corporation, or other business entity to which the prime contractor sublets, or proposes to sublet, any portion of a contract.

§9.52. Policy.

It is the policy of the department that:

(1) DBEs and HUBs shall have the maximum opportunity to participate in the performance of contracts;

(2) all necessary and reasonable steps will be taken to ensure that DBEs and HUBs have maximum opportunity to compete for and perform contracts and subcontracts; and

(3) discrimination is prohibited on the basis of race, color, national origin, or gender in the award and performance of contracts.

§9.53. Applicability.

(a) The DBE program is applicable to all department contracts and purchases funded in whole or in part with federal funds received from the United States Department of Transportation through the Federal Highway Administration, Federal Transit Administration, or the Federal Aviation Administration.

(b) The HUB program is applicable to all department contracts and purchases funded entirely with state and local funds. §9.54. DBE/HUB Goals. The department will periodically establish overall annual DBE and HUB participation goals. The goals will be published in the Texas Register and other media as appropriate. Individual contract goals will be established to achieve the overall goal.

(1) Annual goals.

(A) DBE goals. Each year the department will establish an agency DBE goal developed after a review of results of previous efforts to contract with DBEs, an estimate of the number and types of contracts to be awarded in the next federal fiscal year, and a projection of the availability of DBEs to compete for contracts. The annual goal will be consistent with the federal requirements of the U.S. Department of Transportation, and compatible with other applicable state and federal laws.

(B) HUB goals. The department will periodically establish agency HUB contracting goals consistent with GSC goals set forth at Title 1, Texas Administrative Code, §111.13 (relating to Annual Procurement Utilization Goals).

(2) Contract goals. Individual contracts having the potential for DBE/HUB participation are assigned participation goals based on the availability of qualified DBE/HUBs, work site location, dollar value of the contract, and type of work items specified in the contract.

(A) DBE goals. The department will assign individual contract goals for DBE participation in highway improvements, building construction and maintenance, professional services, aviation, public transportation, private consultant services, and purchasing contracts.

(B) HUB goals. Pursuant to Title 1, Texas Administrative Code, §111.13 (relating to Annual Procurement Utilization Goals), the commission will establish HUB goals for individual contracts.

§9.55. Good Faith Effort.

(a) The department will make a good faith effort to meet or exceed the annual goals as described in §9.54 of this title (relating to DBE/HUB Goals).

(b) When a specific contract goal is not being met by a contractor, the contractor must document the steps taken in good faith to obtain DBE/HUB participation.

(1) DBE. The department will consider the following efforts to determine if a contractor has made a good faith effort to meet the DBE contract goal. The list provided is not intended to be mandatory, nor is the list intended to be exclusive. The department

will examine the contractor's efforts and consider the extent of the efforts concerning:

(A) attendance at a pre-bid meeting;

(B) advertisement of the contracting opportunity to the organizations on the clearinghouse list;

(C) written notification of the contracting opportunities available to five firms or 10%,whichever is greater, of the DBE firms listed in the DBE directory provided in §9.56(k) of this title (relating to DBE Certification):

(i) under each category of work identified by the contractor for subcontracting; and

(ii) as willing to work in the district where the project is located.

(D) follow-up with DBE firms to determine interest in the initial solicitation;

(E) selection of work that could be performed by DBE firms;

(F) efforts to negotiate with DBE firms for specific categories of work;

(G) reasons for rejecting a bid or proposal submitted by a DBE firm;

(H) efforts made to provide information to DBEs concerning obtaining bonds and insurance;

(I) effective use of services of available minority community organizations, minority contractors' groups, local, state and federal minority business assistance offices, and other organizations that provide assistance in the recruitment and placement of DBEs certified by the department; and

(J) other efforts relevant to meeting the goals.

(2) HUB. The department will consider a contractor to have made a good faith effort by complying with Title 1, Texas Administrative Code, §111.14 (relating to Subcontracts).

§9.56. DBE Certification.

(a) Responsibility. The department will certify a small business as a DBE, upon request, if it qualifies with certification standards listed in subsection (d) of this section. Firms are certified for a two year period with an annual update required.

(b) Requests. A business must submit a written request for certification as a DBE using an application form approved by the department. A DBE firm may renew its certification using an abbreviated application unless the following situations require that the long form be completed:

(1) a DBE's certification has lapsed;

(2) the firm's previous application was withdrawn; or

(3) there is a change of ownership or control of a certified firm at any time.

(c) Out of state firm. An out of state firm must be certified by the resident state department of transportation or equivalent agency.

(d) Certification standards. A firm must meet each of the following eligibility standards to be certified.

(1) Size. The firm must be a small business concern.

(A) The firm must meet the criteria included in §3 of the Small Business Act and 13 CFR Part 121 to be considered a small business concern. A firm will be required to furnish financial documentation for up to four complete years, if applicable.

(B) If a firm is not a small business concern according to the standards promulgated at 13 CFR Part 121, the department will not certify the firm as a DBE even though it may be owned and controlled by minorities, women, or socially and economically disadvantaged individuals, and is eligible in all other respects.

(2) Social and economic disadvantage status. At least 51% of the firm or, in the case of any publicly owned business, at least 51% of the stock must be owned by one or more socially and economically disadvantaged individuals. The following groups are eligible for social and economic disadvantage status.

(A) An applicant who has been approved as an SBA 8(a) firm.

(B) An applicant may establish his or her membership in a bona fide minority group on the basis of the individual's claim that he or she is a member of a minority group and is so regarded by that particular minority community. The department will not certify a firm as a DBE if it determines the applicant's claim to be invalid.

(C) If an individual is not a member of a minority group or a woman, but can prove social and economic disadvantage on an individual basis using standards set forth in Appendix C to Subpart D, Guidance for Making Determinations of Social and Economic Disadvantage, 49 CFR Part 23, the department will consider that individual to be socially and economically disadvantaged.

(3) Independent, operational business. A business must be existing, operational, independent, and for-profit. The department will consider the date the business was established, the adequacy of its resources and its expertise for the work of the contract and the degree to which financial, equipment leasing, and other relationships with non-minority firms vary from industry practice. Recognition of the business by the Internal Revenue Service as a separate entity for tax or corporate purposes is not in itself sufficient for DBE certification.

(4) Ownership control. The management and daily business operations must be controlled by one or more of the socially and economically disadvantaged individuals who own it. The ownership and control by minorities or women must be real, substantial, and continuing, and must go beyond the form of the ownership as reflected in its ownership documents.

(A) The minority or women owners must enjoy the customary incidents of ownership and must share in the risks and profits commensurate with their ownership interests, as demonstrated by an examination of the substance rather than the form of the arrangement.

(B) The minority or women owners must possess and exercise the power to direct or cause the direction of the management and policies of the firm and to make the day-to-day as well as major decisions on matters of management, policy, and operations.

(C) A firm must not be subject to any formal or informal restrictions which limit the customary discretion of the minority or women owners, including, but not limited to, bylaw provisions, partnership agreements, third-party agreements, or charter

requirements for cumulative voting rights or other rules that prevent the minority or women owners from making a business decision of the firm without the cooperation or vote of any owner who is not a minority or woman.

(5) Management responsibility and control. If the owners of a firm who are not minorities or women are disproportionately responsible for the operation of the firm, the firm will not be considered a DBE. Where the actual management of the firm is contracted out to individuals other than the owner, those persons who have the ultimate power to hire and fire the managers will be considered as controlling the business.

(6) Securities. The minorities or women must directly hold all securities constituting ownership and/or control of a corporation for purposes of establishing it as a DBE. The department will not consider securities held in trust for any reason in determining the ownership or control of the corporation.

(7) Real and substantial contribution. The minority or women owners' contributions of capital or expertise to acquire their interests in the firm must be real and substantial. A promise to contribute capital, a note payable to the firm or its owners who are not socially and economically disadvantaged, or the participation as an employee rather than a manager constitute insufficient contributions by the minority or women owners.

(8) Special considerations. The department will give special consideration and careful review to:

(A) newly formed firms and firms whose ownership and/or control has changed since the date of the advertisement of a contract under which the new firm will contract to determine reasons affecting the timing of the formation of or change in ownership or control;

(B) previous and/or continuing employer-employee relationship between or among present owners to determine that the minority or woman owner has management responsibilities and capabilities described in paragraphs (4)-(6) of this subsection; and

(C) any relationship between a DBE and a non-DBE business having an interest in the DBE to determine if the interest of the non-DBE conflicts with ownership and control requirements.

(e) Certification categories.

(1) Schedule A. This category includes, but is not limited to, trucking firms, manufacturers, regular dealers, construction firms, general contractors, and specialty contractors. A firm may apply for DBE status using the Schedule A application form.

(A) Construction firms, general contractors and specialty contractors. The department will certify a firm as a DBE if it meets all other certification requirements set forth in subsection (d) of this section.

(B) Regular dealers. The department will certify a firm as a DBE if it meets all other certification requirements set forth in subsection (d) of this section, engages in the purchase and sale of the products as its principal business and in its own name, is not a broker or packager; and

(i) owns, operates, or maintains a store, warehouse, or other establishment in which materials or supplies required for a contract are bought, kept in stock, and regularly sold to the public in the usual course of business; or

(ii) is a dealer in bulk items such as steel, cement, gravel, stone, and petroleum products not kept in stock which are distributed or delivered using equipment owned or operated by the firm.

(C) DBE manufacturer. The department will certify a manufacturer as a DBE if it:

(i) meets all other certification requirements set forth in subsection (d) of this section; and

(ii) operates or maintains a factory or an establishment that produces on the premises materials or supplies to be used in a contract.

(D) Disadvantaged trucking firm. The department will certify a trucking firm as a DBE trucking firm if it:

(i) meets all other certification requirements set forth in subsection (d) of this section;

(ii) owns or leases on a long term basis at least two operational trucks; and

(iii) furnishes operators, fuel, maintenance and insurance for all trucks.

(2) Schedule B - Joint venture.

(A) A joint venture may apply for DBE status using the Schedule B application form for a specific project.

(B) The department will certify the joint venture if:

(i) one or more of the partners of the joint venture is a certified DBE;

(ii) the DBE partner is responsible for a clearly defined portion of the work to be performed; and

(iii) the DBE partner shares in the ownership, control, management responsibilities, risks, and profits of the joint venture.

(3) Schedule O - Disadvantaged truck owner-operator.

(A) An independent owner-operator of one truck may apply for disadvantaged truck owner-operator status using the Schedule O application form.

(B) The department will certify a truck owner-operator who:

(i) does not have an employee/employer relationship with a prime contractor:

(ii) is eligible in accordance with subsection (d) of this section;

(iii) proves ownership of the truck;

(iv) proves ability to operate the truck, including, but not limited to, maintaining a commercial driver's license; and

(v) is responsible for maintaining the required insurance on the truck.

(f) On-site review.

(1) The department will conduct an on-site review, in accordance with 49 CFR §23.45, of any firm when:

(A) it applies for DBE certification for the first time;

(B) certification is challenged by a third party; or

(C) the department questions its DBE eligibility.

(2) If the review involves a certified firm, the firm's certification remains valid unless the BOP Office notifies the firm in writing that its certification is suspended during the review.

(3) If the on-site review indicates that the firm meets eligibility standards, the firm will be certified or remain certified.

(4) If the on-site review indicates that the firm does not meet eligibility standards, the firm will be denied certification in accordance with subsection (i) of this section.

(g) Certification renewals.

(1) DBE certifications are valid for two years with an annual update required.

(2) To be recertified as a DBE, a firm must submit a written application.

(3) Renewals are subject to certification standards set forth in subsection (d) of this section.

(h) Third-party actions.

(1) Social and economic challenge.

(A) A third party may challenge the social and economic disadvantaged status of an owner of a certified firm or a firm seeking to be certified as a DBE unless the firm has a current SBA 8(a) certification as provided in 49 CFR §23.69.

(B) A challenge must be made in writing, signed and dated by the challenger, and set forth the factual basis for the challenge.

(C) DBE certification remains valid during department proceedings.

(D) After receiving a written challenge, the department will determine if there is reason to believe that the challenged party is in fact not socially and economically disadvantaged on the basis of the information provided by the challenging party.

(E) If the department based certification upon SBA 8(a) program certification pursuant to 49 CFR §23.62, the department will refer the challenging party to the Small Business Administration.

(F) If the department based certification upon an applicant's claim to be socially and economically disadvantaged, and if there is a basis to believe that the challenged party is not socially and economically disadvantaged, the department will:

(i) notify the firm in writing that the individual's social/economic disadvantaged status has been challenged, identify the challenging party, summarize the grounds for the challenge, and request information to be submitted within 15 working days to substantiate their claim of social and economic disadvantage;

(ii) make a determination of social and economic disadvantage according to standards set forth in Appendix C to Subpart D, Guidance for Making Determinations of Social and Economic Disadvantage, 49 CFR Part 23; and

(iii) notify both parties in writing, setting forth reasons for the determination, and asking each party to respond in writing to the determination.

(G) If both parties accept the department's determination, the challenge is closed.

(H) If either party is aggrieved by the department's determination, the aggrieved party may request an eligibility conference in accordance with subsection (j) of this section.

(2) DBE Certification.

(A) A third party who alleges that another firm has been wrongly denied or granted certification as a DBE or joint venture may advise the U.S. Department of Transportation pursuant to 49 CFR §23.55.

(B) The U.S. Department of Transportation may deny participation as a DBE during the pendency of the investigation after providing the DBE or joint venture an opportunity to show cause by written statement why participation should not be denied.

(3) HUB Certification Challenge. A challenge regarding a firm's eligibility as a HUB based on the department's certification process must be submitted to the department for resolution.

(i) Denial of certification.

(1) The department will notify an applicant in writing if certification is to be denied and set forth reasons for denial.

(2) An applicant who withdraws its application may reapply at any time.

(3) An applicant may answer the department's notice of denial within 15 working days after receiving notice of denial.

(A) If the applicant does not answer within the 15 day period, the denial of certification is final.

(B) If an applicant answers within the 15 day period, and the response resolves eligibility deficiencies, the department will certify the applicant.

(C) If an applicant answers within the 15 day period, but does not resolve eligibility deficiencies, the applicant may accept the department's denial of certification or it may request an eligibility conference.

(j) Eligibility conference.

(1) An applicant who believes the department has wrongly denied certification may request an eligibility conference no later than 15 days after receiving notification of the department's denial of certification.

(2) A third party who has challenged a firm's social and economic status pursuant to subsection (h)(1) of this section may request an eligibility conference no later than 15 days after receiving notification of the department's determination.

(3) During an eligibility conference, the applicant, challenged firm, or challenging party may submit additional information to substantiate or refute eligibility.

(4) The department will include the information received pursuant to paragraphs (1)-(3) of this subsection in its final determination.

(5) An applicant denied certification must wait six months from the date of denial to reapply for certification.

(6) Any party aggrieved by the department's certification determination may appeal to the U.S. Department of Transportation in accordance with §9.61 of this title (relating to Appeals).

(k) DBE directory. The department will maintain a directory of certified DBEs. Monthly amendments to the directory will be sent to prequalified contractors indicating deletions and decertification.

§9.57. HUB Certification.

(a) The department and GSC will operate under a reciprocal certification program for minority and women-owned businesses. A general operating agreement between the agencies will be developed outlining the policies and procedures for managing the reciprocal certification program. The GSC certifies businesses as HUBs using procedures set forth at Title 1, Texas Administrative Code, §§111.11-111.23. A business denied HUB certification though GSC's certification process may appeal the GSC determination in accordance with procedures set forth at Title 1, Texas Administrative Code, §111.14 (relating to Protests). A business denied DBE/HUB certification through the department's certification process may seek review of the denial as described in §9.56 (i) and (j) of this title (relating to DBE Certification).

(b) The department will submit information regarding DBEs who qualify as HUBs to GSC for certification.

(c) GSC maintains a directory of certified HUBs.

§9.58. Contract Compliance.

(a) Contract provision. Department contracts involving the expenditure of funds will include a contract provision addressing DBE or HUB requirements.

(1) A contract with a goal assigned will include a provision which sets forth program requirements for the type of contract receiving the goal, including, but not limited to, the department's DBE/HUB policy, the DBE/HUB contract goal, good faith efforts, honoring commitments, DBE/HUB substitutions, nondiscrimination, crediting procedures, commercially useful function, contract modifications, reporting requirements, maintenance of records, compliance procedures, enforcement, and sanctions for noncompliance with the terms of the contract provision.

(2) A contract without a goal assigned will include provisions;

(A) encouraging the use of minority, disadvantaged, and historically underutilized business enterprises in subcontracting activities; and

(B) prohibiting discrimination.

(b) Monitoring. The department will monitor contractor compliance by:

(1) reviewing contractor reports; and

(2) making on-site visits to the project or the offices of a contractor or subcontractor.

(c) Contractor representative. A contractor receiving a contract with an assigned goal must designate an employee to serve as a DBE/HUB contact person during the contract, and must inform the department of the representative's name, title, and telephone number no later than five days after the contract is signed. The DBE/HUB representative is responsible for submitting reports, maintaining records, and documenting good faith efforts to use DBE/HUBs pursuant to §9.55 of this title (relating to Good Faith Effort).

(d) Commitments. The following requirements must be satisfied by the contractor unless the contractor is a DBE/HUB.

(1) After the award of a contract, the contractor must within the time period specified in the award document furnish a list of commitments made to certified DBE/HUBs to meet the contract goal along with a commitment agreement containing the original signatures of the contractor and the proposed DBE/HUB which includes, but is not limited to:

(A) a statement that the contractor intends to provide the DBE/HUB the opportunity to perform the subcontract;

(B) the items of work to be performed;

(C) the quantities of work or material;

(D) the unit measure, unit price, and total cost for each item;

(E) the total amount of the DBE/HUB commitment; and

(F) if the commitment involves a DBE/HUB material supplier, an explanation of the function to be performed and a description of any arrangements, including joint check agreements, made with other material suppliers, manufacturers, distributors, hauling firms, or freight companies.

(2) The contractor must document good faith efforts taken to meet the goal in accordance with:

(A) §9.55 of this title (relating to Good Faith Efforts); and

(B) applicable contract provisions.

(e) Reporting. Each contractor receiving a contract with an assigned goal must submit the following reports.

(1) The contractor must submit periodic reports at intervals specified in the contract using a report form acceptable to the department that includes, but is not limited to, identification of the DBE/HUB by name and vendor number, and showing the actual amount paid to the DBE/HUB. The report must be submitted even if no payments were made during the period being reported. When required by the department, the contractor must attach proof of payment including, but not limited to, copies of canceled checks.

(2) The contractor must submit a final report in accordance with the contract, using a form acceptable to the department which shows:

(A) the total paid to each DBE/HUB; and

(B) if the contract goal is not met, a description of good faith efforts taken in accordance with:

(i) §9.55 of this title (relating to Good Faith Efforts); and

(ii) applicable contract provisions.

(f) Credit for expenditures.

(1) Full credit for federal aid contracts. A contractor awarded a federal aid contract will receive credit for all payments

made to a DBE firm certified in accordance with §9.56 of this title (concerning DBE certification) unless:

(A) a DBE firm is paid but does not assume contractual responsibility for providing the goods or performing the services;

(B) a DBE firm does not perform a commercially useful function as set forth in subsection (g)(1) of this section;

(C) a contractor makes payment directly to a material supplier for the cost of materials or supplies used by a DBE subcontractor unless the payment is made with a joint check to the DBE subcontractor and the material supplier in accordance with an invoice submitted by the material supplier;

(D) a contractor deducts payment of the cost of materials used by a DBE subcontractor or the cost of leased or rented equipment used by the DBE/HUB from an invoice submitted by the DBE;

(E) a payment is made:

(i) to a DBE that cannot be linked by an invoice or canceled check to the contract under which credit is claimed;

(ii) to a broker or a firm with a brokering-type operation;

(iii) to a DBE manufacturer for a product purchased for the project and not manufactured by the DBE manufacturer;

(iv) to a DBE trucking firm that does not perform 30% of the contract with trucks owned or leased on a long term basis or with owner-operators, and does not furnish operators, fuel, maintenance and insurance for the owned or leased trucks;

(v) for the amount of materials and supplies required on a job site, when the hauler, trucker, or delivery service is not also a manufacturer of or a regular dealer in the materials and supplies; or

(vi) for a bona fide service, such as professional, technical, consultant, or managerial services, and assistance in the procurement of essential personnel, facilities, equipment, materials, or supplies required for performance of the contract (The credit is reduced to the amount of the fee or commission charged provided the fee or commission does not exceed that customarily allowed for similar services); or

(2) Partial credit for federal aid contracts. A contractor awarded a federal aid contract will receive:

(A) 60% for payment to a regular dealer;

(B) the percentage of DBE ownership in the joint venture for payment to a joint venture; or

(C) the amount of any fee or commission charged for providing any bonds or insurance specifically required for the performance of the contract, provided that the fee or commission does not exceed that customarily allowed for such fee or commission.

(3) Non-federal aid contracts. A contractor will receive credit for all payments actually made to a HUB for work performed and costs incurred in accordance with the contract with the following exceptions and/or stipulations and only if the arrangement is consistent with standard industry practice.

(A) Payments:

(i) to brokers or firms with a brokering-type operation will be credited only for the amount of the commission;

(ii) to a joint venture will not be credited unless all partners in the joint venture are HUBs;

(iii) to a HUB subcontractor who has subcontracted a portion of the work required under the subcontract will not be credited unless the HUB performs a commercially useful function;

(iv) to a HUB firm will not be credited if the firm does not provide the goods or perform the services paid for;

(v) made by a contractor directly to a material supplier for the cost of materials or supplies used by a HUB subcontractor will not be credited unless payment is made, from an invoice submitted by the supplier, with a joint check to the supplier and HUB;

(vi) made to a HUB supplier not directly involved in the manufacture or distribution of the supplies or materials or who does not otherwise warehouse and ship the supplies will not be credited; or

(vii) made to a HUB that cannot be linked by an invoice or canceled check to the contract under which credit is claimed will not be credited.

(B) Deductions made by a contractor for the cost of materials used by a HUB subcontractor or the cost of leased or rented equipment used by the HUB from an invoice submitted by the HUB will not be credited.

(4) The department may request a contractor to furnish proof of payment made to a DBE/HUB firm including, but not limited to, canceled checks to substantiate expenditures.

(5) A contractor must not withhold or reduce payments to any DBE/HUB firm without a reason that is accepted as standard industry practice.

(g) Performance. A DBE/HUB contractor or subcontractor must comply with the terms of the contract or subcontract for which it was selected. Work products, services, and commodities must meet contract specifications whether performed by a contractor or subcontractor.

(1) Commercially useful function.

(A) DBE subcontractors must perform a commercially useful function required in the contract in order for payments to be credited toward meeting the contract goal. A DBE performs a commercially useful function when it:

(i) is responsible for a distinct element of the work of a contract; and

(ii) actually manages, supervises, and controls the materials, equipment, employees, and all other business obligations attendant to the satisfactory completion of contracted work.

(B) The department may conduct an on-site review of a DBE/HUB's performance to determine that it is performing a commercially useful function as part of its routine monitoring program or in response to information or allegations that the DBE is not performing a commercially useful function.

(C) If the department determines that a DBE/HUB firm is not performing a commercially useful function under the contract, the department may:

(i) suspend the DBE/HUB firm from the DBE/HUB program for a period to be determined by the department;

(ii) deny all credit if the prime contractor did the work itself or directed another company to do the work, or deny credit from the time the department determined and notified the prime contractor that the DBE/HUB did not perform a commercially useful function;

(iii) review DBE certification; and

(iv) revoke DBE certification if an eligibility review indicates that the firm does not meet the standard as described in §9.56 of this title (relating to DBE Certification).

(D) A DBE may appeal the department's determination to U.S. Department of Transportation pursuant to 49 CFR §23.47.

(2) Subcontracting.

(A) A DBE contractor or subcontractor may subcontract no more than 70% of a federal aid contract. The DBE shall perform not less than 30% of the value of the contract work with:

(i) assistance of employees employed and paid directly by the DBE; and

(ii) equipment owned or rented directly by the DBE.

(B) A HUB prime contractor must perform at least 25% of a nonfederal aid contract with its employees (as defined by the Internal Revenue Service). A HUB prime contractor may subcontract the remaining 75% of the contract to a HUB or non-HUB firm.

(C) A HUB subcontractor may subcontract 75% of a nonfederal aid contract as long as the HUB subcontractor performs a commercially useful function. If the subcontractor uses an employee leasing firm for the purpose of providing salary and benefit administration, the employees must in all other respects be supervised and perform on the job as if they were employees of the subcontractor.

(D) A contractor may not furnish work crews or equipment to a DBE/HUB subcontractor.

(i) A DBE may lease equipment consistent with standard industry practice. A DBE may lease equipment from the prime contractor provided a rental agreement, separate from the subcontract specifying the terms of the lease arrangement, is approved by the department prior to the DBE starting the work. If the equipment is of a specialized nature, the lease may include the operator. If the practice is generally acceptable within the industry, the operator may remain on the lessor's payroll. The operation of the equipment shall be subject to the full control of the DBE, for a short term, and involve a specialized piece of heavy equipment readily available at the job site.

(ii) For equipment that is not specialized, the DBE shall provide the operator and be responsible for all payroll and labor compliance requirements.

(3) Maximum opportunity. A contractor must allow a DBE/HUB maximum opportunity to perform the work by not creating unnecessary barriers or artificial requirements for the purpose of hindering a DBE/HUB's performance under the contract such as, but not limited to:

(A) inadequate notice to perform work;

(B) failure to make timely payments; and

(C) failure to prepare the worksite on schedule.

(h) Substitutions. A contractor must request approval from the department to subcontract with a DBE/HUB firm other than the firm originally authorized.

(1) A contractor must provide written justification for a request to substitute a DBE/HUB firm, including, but not limited to, demonstrating that the original firm is unable or unwilling to carry out the terms of the subcontract.

(2) The department will contact the DBE/HUB to be displaced and other parties as needed to determine if the DBE/HUB firm to be displaced is willing and able to carry out the terms of the contract.

(A) The term "unable" includes, but is not limited to:

(i) a firm that does not have the resources and expertise to finish the project;

(ii) a firm that substantially increases the time to complete the project causing liquidated damages; or

(iii) a firm that creates a safety hazard.

(B) If the displaced firm is unwilling or unable to carry out the terms of the subcontract, the department will notify the contractor in writing within five working days of the request of its consent to the substitution, and the contractor must make a good faith effort to substitute another certified DBE/HUB firm for the one being displaced if the cancellation of the DBE/HUB subcontract results in the prime not meeting the goal.

(3) Any party aggrieved by the determination effecting the substitution of subcontractors may avail itself of the complaint procedures under §9.59 of this title (relating to Complaints).

(i) Records. A contractor must retain all records specified in the contract provisions for three years after final payment is made under the contract, or until any investigation, audit, examination, or other review undertaken during the three years is completed. The records must be made available to representatives of the department and other agencies for inspection, audit, examination, investigation, or other review at all reasonable times during the retention period.

(j) Compliance conference. The following process is made available to the contractor whenever a finding of noncompliance with DBE/HUB special provisions is made by the department. A contractor involved in a violation may be given an opportunity to remedy the violation before the department issues sanctions.

(1) A letter will be sent to the contractor notifying the contractor that it is not in compliance with the DBE/HUB special provision in the contract.

(2) The contractor may respond in writing. If the written response does not resolve the issues, the department will invite the contractor to attend an informal compliance conference, within 15 calendar days from the date of the written response, to discuss the issues.

(3) The contractor will be given 15 calendar days from the date of the conference to submit additional information to resolve the issues.

(4) The department will make a final determination regarding compliance within 15 calendar days from the conference or receipt of any additional information.

(5) If a determination of noncompliance has been made by the department, a contractor will be given an opportunity to submit a voluntary written corrective action plan to correct the violations.

(6) When a contractor fails to take corrective actions, the department may issue a notice to the contractor to show cause for noncompliance and why enforcement proceedings should not be instituted.

(7) The department may impose sanctions, pursuant to subsection (k) of this section, for failure to show cause why enforcement proceedings should not be instituted.

(k) Sanctions.

(1) The department may issue sanctions to a contractor that does not comply with contract requirements.

(2) If a successful bidder for a highway improvement contract does not furnish the required DBE/HUB commitment information during the time period specified in the DBE/HUB special provision, the department may declare the contractor to be in default and retain the proposal guaranty as liquidated damages in accordance with §9.18 of this title (relating to After Contract Award).

(3) The department will impose sanctions if the contractor:

(A) is found to have discriminated against a DBE/HUB firm;

(B) has failed to meet the contract DBE/HUB goal and has failed to demonstrate a good faith effort to meet the goal;

(C) DBE/HUB commitments were not kept; or

(D) DBE/HUB firms were not given the maximum opportunity to perform under a subcontract.

(4) The department may impose any of the following sanctions:

(A) letter of reprimand;

(B) liquidated damages computed up to the amount of goal dollars not met;

(C) contract termination; and/or

(D) other remedies available by law.

(5) Factors to be considered in issuing sanctions may include, but are not limited to:

(A) the magnitude and the type of the offense;

(B) the degree of the contractor's culpability;

(C) any steps taken to rectify the situation;

(D) the contractor's record of performance on other projects including, but not limited to:

(i) annual DBE/HUB participation over DBE/HUB goals;

(ii) annual DBE/HUB participation on projects without goals or payment incentives;

(iii) number of complaints the department has received from DBEs/HUBs; and

(iv) the number of times the contractor has been previously sanctioned by the department pursuant to this section; and

(E) whether a contractor falsified, misrepresented, or withheld information.

(6) A contractor may appeal the department's sanction to the Business Appeals committee pursuant to §9.61 of this title (relating to Appeals).

§9.59. Business Complaints.

(a) Filing of complaint. A complaint related to a federally funded contract may be filed directly with the U.S. Department of Transportation at any time within 180 days of the date of an alleged discrimination or a violation of the DBE Program, or the dates on which a continuing course of conduct in violation was discovered.

(b) Contractor claims. A claim for additional compensation or time extension for any reason under a contract between the department and a prime contractor will be heard in accordance with §9.2 of this title (relating to Contract Claim Procedures).

(c) Bidder/proposer protest.

(1) A firm may file a written protest with the DED for any reason under this subchapter, including discrimination, within 90 calendar days after being notified that it was not awarded or selected to receive a contract offered by the department.

(2) The DED or his or her designee will forward the department's written response to the protesting firm.

(3) If the protesting firm accepts the response, further appeal is barred.

(4) If the protesting firm is not satisfied with the response, it may request an investigation in accordance with §9.60 of this title (relating to Investigation), or file an appeal with the U.S. Department of Transportation in accordance with §9.61 of this title (relating to Appeals).

(d) Program administration complaint.

(1) An aggrieved firm or person who believes that person or firm, another person, or any specific class of individuals to be subject to a violation of this subchapter, including discrimination, may file a written complaint with the DED or his or her designee.

(2) A written complaint must be filed no later than 90 calendar days after the date of an alleged violation or the date on which a continuing course of conduct in violation of the program was disclosed.

(3) The DED or his or her designee will seek to resolve the complaint with the involved parties.

(A) If the complaint is resolved as a result of this contact, no further action is necessary.

(B) If the complaint is not resolved, the DED or his or her designee will furnish the aggrieved party with the complaint procedures set forth at §9.60 of this title (relating to Investigation).

(C) A disputant who does not request a formal investigation may appeal to the U.S. Department of Transportation as provided at §9.61 of this title (relating to Appeals) if the contract is federally funded.

§9.60. Investigation.

(a) If a person or business is aggrieved by a finding, response, or determination resulting from any protest, complaint, or dispute under §9.59 of this title (relating to Business Complaints), except for certification and contractor claims under §9.2 of this title (relating to Contract Claim Procedure), the aggrieved person or business may request a formal investigation into the protest, complaint, or dispute. The request must be made in writing within the time period specified in the complaint procedure at §9.59 of this title (relating to Business Complaints).

(b) The Civil Rights Division will review the prior proceedings and determine that either:

(1) there is no valid reason for further action, notifying the disputant of the determination and setting forth the reasons for taking no further action; or

(2) an investigation is warranted, notifying the disputant.

(c) The aggrieved person or business will be referred to as the complainant. The department or contractor or any employee of the contractor will be referred to as the respondent.

(d) If the complainant is a department employee or applicant, the investigation will be conducted in accordance with department policy set forth in the department's Human Resources Manual.

(e) The Civil Rights Division will notify the appropriate agencies of the investigation, meet separately with the complainant and respondent, and prepare a report of investigation.

(1) If the investigation finds no cause for the complaint, the department will issue a finding of no cause.

(2) If the investigation finds cause for the complaint, the DED or his or her designee will meet with the complainant and respondent to discuss a conciliation agreement.

(A) If the parties concur, the DED or his or her designee will prepare a conciliation agreement for execution, and monitor the agreement to completion.

(B) If the respondent does not agree to a conciliation agreement, the appropriate deputy or assistant executive director will make a final determination of corrective action needed. The DED or his or her designee will monitor corrective actions undertaken by the respondent.

(C) If the final determination made by the deputy or assistant executive director is not acceptable to one of the parties, the aggrieved party may appeal to the Business Appeal Committee in accordance with §9.61 of this title (relating to Appeals).

(D) If an appeal is not filed within 10 days after receiving notice of final determination, the determination made by the assistant or DED or his or her designee will be final and further administrative appeal will be barred.

§9.61. Appeals.

(a) Appeal to U.S. Department of Transportation.

(1) A firm may file an appeal with U.S. Department of Transportation at any time pursuant to the process outlined in:

(A) 49 CFR §23.55, if a firm believes that it has been wrongly denied certification under §9.56 of this title (relating to DBE Certification);

(B) 49 CFR §23.69, if a firm has challenged certification under §9.56(h) of this title (relating to DBE Certification), except for SBA 8(a) certification; or

(C) 49 CFR §23.73, if a firm alleges discrimination on a federally funded contract under §9.59 of this title (relating to Complaints) or is aggrieved by a department determination related to the DBE program.

(2) The appeal must be made in writing, signed and dated, no later than 180 days after the date of the offense or the date on which a continuing course of conduct in violation was discovered. The Secretary of Transportation may extend the time for filing or waive the time limit in the interest of justice.

(3) The outcome of the U.S. Department of Transportation appeal process is final.

(b) Department appeals.

(1) The BAC will hear appeals relating to sanctions pursuant to §9.58 of this title (relating to Contract Compliance and complaints pursuant to §9.59 of this title (relating to Business Complaints), other than contractor claims set forth at §9.2 of this title (relating to Contractor Claims) and certification if the appealing party identifies:

(A) new information or witnesses that, if considered, might have changed the outcome;

(B) harmful procedural error by the department which, had it not been made, could have led to a different conclusion; or

(C) a finding contrary to the evidence, department policy, or law.

(2) An aggrieved person, contractor, or subcontractor involved in a contract complaint or any other complaint involving discrimination or any aspect of the DBE/HUB program becomes the appellant when appealing a finding of a formal investigation set forth at §9.60 of this title (relating to Investigation).

(3) BAC will review:

(A) the sanction determination made in accordance with §9.58 of this title (relating to Contract Compliance); or

(B) the finding of the investigation conducted in accordance with §9.60 of this title (relating to Investigation),

(4) The appellant may rebut the proposed sanction determination or investigative finding.

(5) BAC may secure detailed reports from the affected parties and confer informally with the appellant and the department.

(6) BAC will give written notice of the finding to the appellant. If the finding is acceptable to the appellant, the appellant shall advise the committee chairman in writing within 20 days of the date such notice is received, and the chairman will forward the agreed

disposition to the executive director for a final and binding order on the complaint.

(7) Proceedings before the BAC are an attempt to mutually resolve a business complaint without litigation and are not admissible for any purpose in a formal administrative hearing.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701496
Bob Jackson
Deputy General Counsel
Texas Department of Transportation
Earliest possible date of adoption: March 14, 1997
For further information, please call: (512) 463-8630

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WITHDRAWN RULES

An agency may withdraw a proposed action or the remaining effectiveness of an emergency action by filing a notice of withdrawal with the ***Texas Register***. The notice is effective immediately upon filling or 20 days after filing as specified by the agency withdrawing the action. If a proposal is not adopted or withdrawn within six months of the date of publication in the ***Texas Register***, it will automatically be withdrawn by the office of the Texas Register and a notice of the withdrawal will appear in the ***Texas Register.***

TITLE 25. HEALTH SERVICES

Part XVI. Texas Health Care Information Council

Chapter 1301. Health Care Information

Collection and Release of Hospital Discharge Data

25 TAC §§1301.11-1301.19

The Texas Health Care Information Council has withdrawn from consideration for permanent adoption the proposed new to §§1301.11-1301.19, which appeared in the August 23, 1996, issue of the *Texas Register* (21 TexReg 7939).

Issued in Austin, Texas, on January 30, 1997.

TRD-9701379
Jim Loyd
Director of Program Planning
Texas Health Care Information Council
Effective date: January 30, 1997
For further information, please call: (512) 424-6492

♦ ♦ ♦

Collection and Reporting of Health Plan Employer Data and Information Set (HEDIS) from Health Maintenance

25 TAC §§1301.31-1301.35

The Texas Health Care Information Council has withdrawn from consideration for permanent adoption the proposed new to §§1301.31-1301.35, which appeared in the October 15, 1996, issue of the *Texas Register* (21 TexReg 10161).

Issued in Austin, Texas, on January 30, 1997.

TRD-9701380
Jim Loyd
Director of Program Planning
Texas Health Care Information Council
Effective date: January 30, 1997
For further information, please call: (512) 424-6492

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ADOPTED RULES

An agency may take final action on a section 30 days after a proposal has been published in the ***Texas Register***. The section becomes effective 20 days after the agency files the correct document with the ***Texas Register***, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice.

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published. If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes.

TITLE 1. ADMINISTRATION

Part V. General Services Commission

Chapter 111. Executive Administration Division

Cost of Copies of Open Records

1 TAC §111.63

The General Services Commission adopts an amendment to §111.63(g)(2), concerning allowable personnel charges for remote document retrieval without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11904).

The amendment to §111.63(g)(2) is being adopted in order to correct an erroneous cite.

The amendment will provide clearer rules for all governmental bodies in providing access to, and copies of public information.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Government Code, Chapter 552, §552.262, which provides the General Services Commission with the authority to promulgate rules necessary to implement the section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701399
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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Chapter 119. Automated Services Division

1 TAC §119.1

The General Services Commission adopts the repeal of §119.1, concerning requests for information without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11904).

This section is being adopted for repeal in order to delete obsolete language created pursuant to the Texas Civil Statutes, Article 6252-17a, which was repealed by the 73rd Legislative Session, Senate Bill 248, effective September 1, 1993.

The repeal will delete obsolete requirements.

No comments were received regarding adoption of the repeal.

The repeal is adopted under the authority of the Texas Government Code, Chapter 552, Subchapter F, §552.262 (the "Public Information Act") which provides the General Services Commission with the authority to promulgate rules necessary to accomplish the purpose of the section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701398
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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Part VI. Texas Surplus Property Agency

Chapter 141. Donation of Surplus Personal Property Manual

1 TAC §§141.1-141.3

The General Services Commission adopts the repeal of the Texas Surplus Property Agency rules under the Texas Administrative Code, Title 1, §§141.1-141.3, concerning the Donation of Surplus Personal Property Manual without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11905).

These sections are being repealed in order to delete obsolete rules from the Texas Surplus Property Agency which was abolished and the management of its functions transferred

to the General Services Commission by the 73rd Legislative Session, Senate Bill 381, effective September 1, 1993.

The repeal of the Texas Administrative Code, Title 1, §§141.1-141.3 will delete obsolete requirements.

No comments were received regarding adoption of the repeals

The repeals are adopted under the authority of the Texas Government Code, Title 10, Subtitle D, §2175.061.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701405
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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Chapter 143. Plan of Operation

1 TAC §143.1

The General Services Commission adopts the repeal of the Texas Surplus Property Agency rules under the Texas Administrative Code, Title 1, §143.1, concerning the Plan of Operation without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11905).

This section is being repealed in order to delete obsolete rules from the Texas Surplus Property Agency which was abolished and the management of its functions transferred to the General Services Commission by the 73rd Legislative Session, Senate Bill 381, effective September 1, 1993.

The repeal of the Texas Administrative Code, Title 1, §143.1 will delete obsolete requirements.

No comments were received regarding adoption of the repeal.

The repeal is adopted under the authority of the Texas Government Code, Title 10, Subtitle D, §2175.061.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701402
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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Chapter 145. Merit System of Personnel Administration

1 TAC §§145.1–145.23

The General Services Commission adopts the repeal of the Texas Surplus Property Agency rules under the Texas Administrative Code, Title 1, §§145.1 - 145.23, concerning the Merit System of Personnel Administration without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11906).

These sections are being repealed in order to delete obsolete rules from the Texas Surplus Property Agency which was abolished and the management of its functions transferred to the General Services Commission by the 73rd Legislative Session, Senate Bill 381, effective September 1, 1993.

The repeal of the Texas Administrative Code, Title 1, §§145.1 – 145.23 will delete obsolete requirements.

No comments were received regarding adoption of the repeals.

The repeals are adopted under the authority of the Texas Government Code, Title 10, Subtitle D, §2175.061.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701403
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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Chapter 147. Executive

1 TAC §147.1

The General Services Commission adopts the repeal of the Texas Surplus Property Agency rules under the Texas Administrative Code, Title 1, §147.1, concerning the Executive without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11906).

This section is being repealed in order to delete obsolete rules from the Texas Surplus Property Agency which was abolished and the management of its functions transferred to the General Services Commission by the 73rd Legislative Session, Senate Bill 381, effective September 1, 1993.

The repeal of the Texas Administrative Code, Title 1, §147.1 will delete obsolete requirements.

No comments were received regarding adoption of the repeal.

The repeal is adopted under the authority of the Texas Government Code, Title 10, Subtitle D, §2175.061.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701404
Judy Ponder
General Counsel
General Services Commission
Effective date: February 20, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 463–3960

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TITLE 4. AGRICULTURE

Part III. Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist

Chapter 63. Pet Food Rules

4 TAC §63.2

The Feed and Fertilizer Control Service/Office of the Texas State Chemist adopts an amendment to §63.2, concerning Label Format and Labeling, without changes to the proposed text as published in the November 5, 1996, issue of the *Texas Register* (21 TexReg 10858).

This rule is being amended to simplify the requirements for quantity label statements under the United States Fair Packaging and Labeling Act and to reorganize paragraphs (3) and (4) under §63.2(o) to bring Texas Rules into conformity with those of AAFCO. It also ensures that consumers of dog and cat foods are able from the label to determine the appropriate use of the feed which they are purchasing and clarifies the present confusing terminology.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Agriculture Code Chapter 141, §141.004 which provides Texas Feed and Fertilizer Control Service with the authority to adopt rules relating to the distribution of commercial feeds.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701447
Dr. George W. Latimer, Jr.
State Chemist
Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist
Effective date: February 21, 1997
Proposal publication date: November 5, 1996
For further information, please call: (512) 845–1121

♦ ♦ ♦

4 TAC §63.7

The Feed and Fertilizer Control Service/Office of the Texas State Chemist adopts an amendment to §63.7, concerning Drugs and Pet Food Additives, without changes to the proposed text as published in the November 5, 1996, issue of the *Texas Register* (21 TexReg 10858).

This rule is being amended to simplify the requirements for quantity label statements under the United States Fair Packaging and Labeling Act. It will also ensure that consumers of dog and cat foods are able from the label to determine the appropriate use of the feed which they are purchasing and clarifies the present confusing terminology.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Agriculture Code Chapter 141, §141.004, which provides Texas Feed and Fertilizer Control Service with the authority to adopt rules relating to the distribution of

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701448
Dr. George W. Latimer, Jr.
State Chemist
Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist
Effective date: February 21, 1997
Proposal publication date: November 5, 1996
For further information, please call: (512) 845–1121

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4 TAC §63.8

The Feed and Fertilizer Control Service/Office of the Texas State Chemist adopts an amendment to §63.8, concerning Registration of Pet Foods in Packages of Five Pounds or Less, previously titled Application for Registration, without changes in the proposed text as published in the November 5, 1996, issue of the *Texas Register* (21 TexReg 10859).

The amendment is adopted to bring the section of the rules into conformance with the amended Texas Feed Law.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Agriculture Code, Chapter 141, §141.004 which provides Texas Feed and Fertilizer Control Service with the authority to adopt rules relating to the distribution of commercial feeds.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701449
Dr. George W. Latimer, Jr.
State Chemist

Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist

Effective date: February 21, 1997

Proposal publication date: November 5, 1996

For further information, please call: (512) 845–1121

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4 TAC §63.9

The Office of the Texas State Chemist, Feed and Fertilizer Control Service, adopts an amendment to §63.9, concerning Statement of Caloric Content, with changes to the proposed text as published in the November 5, 1996, issue of the *Texas Register* (21 TexReg 10860).

The only change from the proposed text is editorial in nature. It removes the word "and" in subsection (a), paragraph (1).

The rule is amended to bring the Texas Pet Food Rules into conformity with recently adopted AAFCO labeling rules and the new amended Feed Law and clarification of confusing terminology such as "lite," and "reduced calorie."

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Agriculture Code Chapter 141, §141.004 which provides Texas Feed and Fertilizer Control Service with the authority to adopt rules relating to the distribution of commercial feeds.

§63.9. Statement of Caloric Content.

(a) The label of a dog or cat food may bear a statement of caloric content, provided:

(1) the statement shall be separate and distinct from the "Guaranteed Analysis" and shall appear under the heading "Caloric Content";

(2) the statement shall be measured in terms of metabolizable energy (ME) on as fed basis and must be expressed as "kilocalories per kilogram" ("kcal/kg") of product, and may also be expressed as kilocalories per familiar household measure (e.g., cans, cups, pounds); and

(3) an affidavit shall accompany the request for label review substantiating that the caloric content was determined:

(A) by calculation using the following "Modified Atwater" formula: ME (kcal/kg) = 10 (3.5 x CP) + (8.5 x CF) + (3.5 x NFE) where CP = % crude protein as fed, CF = % crude fat as fed, NFE = % nitrogen-free extract (carbohydrate) as fed and the percentages of CP and CF are the arithmetic averages from proximate analyses of at least four production batches of the product, and the NFE is calculated as the difference between 100 and the sum of CP, CF, and the percentages of crude fiber, moisture and ash (determined in the same manner as CP and CF). The results of all the analyses used in the calculation must accompany the affidavit, and the claim on the label or other labeling must be followed parenthetically by the word "calculated";

(B) in accordance with a testing procedure established by the Association of American Feed Control Officials. The summary data used in the determination of calorie content must accompany the affidavit. The value stated on the label shall not exceed or understate the value determined in accordance with subparagraph (A) of this paragraph by more than 15%; and

(4) comparative claims shall not be false, misleading or given undue emphasis and must be based on the same methodology for both products.

(b) Labels of a dog or cat food bearing descriptors of caloric or fat content shall comply with the following:

(1) When using the term "Light," "Lite," "Low Calorie," or words of similar designation:

(A) Dog food product labels shall contain and state no more than 3,100 kcal ME/kg for products containing 15% or less moisture, no more than 2,500 kcal ME/kg for products containing more than 15% but less than 50% moisture, and no more than 900 kcal ME/kg for products containing 50% or more moisture. The label shall bear a calorie content statement. Feeding directions shall reflect a reduction in calorie intake consistent with the intended use.

(B) Cat food product labels shall contain and claim no more than 3,250 kcal ME/kg for products containing 15% or less moisture, no more than 2650 kcal ME/kg for products containing more than 15% but less than 50% moisture, and no more than 950 kcal ME/kg for products containing 50% or more moisture. The label shall bear a calorie content statement. Feeding directions shall reflect a reduction in calorie intake consistent with the intended use.

(2) When using the term "Less" or "Reduced Calories" or words of similar designation, the percentage of reduction and the product of comparison shall be explicitly stated and juxtaposed with the claim in the same size, style, and color print. The product label shall also bear a calorie content statement. Comparisons between products in different categories of moisture content (15% or less, more than 15% but less than 50%, 50% or more) are misleading. Feeding directions shall reflect a reduction in calories compared to feeding directions for the product of comparison.

(3) When using the terms "Lean," "Low Fat," or words of similar designation:

(A) Dog food product labels shall contain and guarantee no more than 9% crude fat for products containing 15% or less moisture, no more than 7% crude fat for products containing more than 15% but less than 50% moisture, and no more than 4% crude fat for products containing 50% or more moisture. The product label shall bear a maximum crude fat guarantee immediately following the minimum crude fat guarantee in addition to the mandatory guaranteed analysis information as specified in §63.2(c) of this title (relating to Label Format and Labeling).

(B) Cat food product labels shall contain and guarantee no more than 10% crude fat for products containing 15% or less moisture, no more than 8% crude fat for products containing more than 15% but less than 50% moisture, and no more than 5% crude fat for products containing 50% or more moisture. The product label shall bear a maximum crude fat guarantee immediately following the minimum crude fat guarantee in addition to the mandatory guaranteed analysis as specified in §63.2(c) of this title.

(4) When using the term "Less," "Reduced Fat," or words of similar designation on cat food labels, the percentage of reduction and the product of comparison shall be explicitly stated and juxtaposed with the claim in the same size, style, and color print. The product label shall also bear a maximum crude fat guarantee

immediately following the minimum crude fat guarantee in addition to the mandatory guaranteed analysis information as specified in §63.2(c) of this title. Comparisons between products in different categories of moisture content (15% or less, more than 15% but less than 50%, 50% or more) are misleading.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701450

Dr. George W. Latimer, Jr.

State Chemist

Texas Feed & Fertilizer Control Service/Office of the Texas State Chemist

Effective date: February 21, 1997

Proposal publication date: November 5, 1996

For further information, please call: (512) 845–1121

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TITLE 19. EDUCATION

Part II. Texas Education Agency

Chapter 89. Adaptations for Special Populations

Subchapter AA. Special Education Services

Clarification of Provisions in Federal Regulations and State Law

19 TAC §89.1115

The Texas Education Agency (TEA) adopts new §89.1115, concerning a memorandum of understanding related to students with disabilities living in residential care facilities. New §89.1115 is adopted with changes to the proposed text as published in the November 22, 1996, issue of the *Texas Register* (21 TexReg 11344).

The interagency agreement, which became effective on June 28, 1996, was entered into by the Texas Education Agency and eight other state agencies at the direction of the Texas Senate Committee on Health and Human Services, 73rd Texas Legislature, 1993. In addition, the interagency agreement provides for: (a) the identification of responsibilities and programs of state agencies that place school-age residents in RCFs, fund these RCF placements, serve these RCF students, and/or regulate these RCFs; (b) the development of policies and procedures for implementing improved interagency coordination with regard to special education to this RCF population, such as increased sharing of information and a required "child find" notice imposed on an RCF as a condition of licensure or regulation; and (c) procedures for resolving disputes that may arise in implementing this agreement.

The following change has been made to new §89.1115 since the section was published as proposed.

Under subsection (i), language has been revised to reflect a change in the address and telephone number for the Texas Commission on Alcohol and Drug Abuse.

The following comment has been received regarding adoption of the new section.

Comment. A representative of the Texas Commission on Alcohol and Drug Abuse (TCADA) requested that the commissioner of education change the address and telephone number for TCADA in subsection (i).

Agency Response. The agency revised the language in subsection (i) as requested.

The new section implements 34 Code of Federal Regulations, §300.152 and §300.600, and the Texas Education Code, §29.001.

§89.1115. Memorandum of Understanding Concerning Interagency Coordination of Special Education Services to Students with Disabilities in Residential Care Facilities.

(a) Introduction.

(1) Purpose of MOU.

(A) As a result of completing investigations and activities directed by the Senate Committee on Health and Human Services, 73rd Texas Legislature, 1993, the parties to this memorandum of understanding (MOU) have recognized the need to strengthen interagency coordination with regard to ensuring that school-age (between birth and 22 years) residents of residential care facilities (RCFs) receive a free appropriate public education, as required under the Individuals with Disabilities Education Act (IDEA), Part B; 20 United States Code (USC), §§1400 et seq. The purpose of this MOU is to address improving interagency coordination with regard to a local education agency's (LEA's) provision of special education services to students with disabilities residing in residential care facilities (RCFs).

(B) Given this purpose, this MOU identifies the following:

(i) responsibilities and programs of state agencies that place school-age residents in RCFs, fund these RCF placements, serve these RCF residents, and/or regulate these RCFs;

(ii) areas where increased, more effective interagency coordination can be accomplished with regard to the provision of special education services;

(iii) procedures and policies for implementing this enhanced level of interagency coordination; and

(iv) procedures for resolving disputes that may arise in implementing this MOU.

(C) The provisions of this MOU will be implemented in a manner consistent with all state and federal laws, and based on existing resources.

(2) Parties to MOU.

(A) The following parties are participating in this MOU because they place school-age individuals in RCFs, fund these RCF placements, serve these RCF residents, and/or regulate these RCFs.

(i) Texas Education Agency (TEA);

(ii) Texas Department of Human Services (TDHS);

(iii) Texas Department of Mental Health and Mental Retardation (TDMHMR);

(iv) Texas Department of Health (TDH);

(v) Texas Department of Protective and Regulatory Services (TDPRS);

(vi) Texas Interagency Council on Early Childhood Intervention (ECI);

(vii) Texas Commission on Alcohol and Drug Abuse (TCADA);

(viii) Texas Juvenile Probation Commission (TJPC); and

(ix) Texas Youth Commission (TYC).

(B) The state agencies specified in subparagraph (A) of this paragraph will be collectively referred to as "parties." Health and human services agencies shall refer to all the parties except TEA.

(3) Relationship to other memoranda of understanding. The following memoranda of understanding have been previously executed and address some of the school-age residents of residential care facilities.

(A) Memorandum of Understanding Defining Responsibilities to Children Who Are Medically Fragile, executed on October 27, 1994, by TEA, Texas Commission for the Blind (TCB), TDH, TDHS, TDMHMR, TDPRS, and ECI.

(B) Memorandum of Understanding Relating to School-Age Residents of Intermediate Care Facilities for the Mentally Retarded, executed in 1992 between TEA and TDHS, 19 Texas Administrative Code (TAC) §89.1105.

(4) Definitions.

(A) Residential care facilities are facilities which provide 24-hour care to more than six students between the ages of birth and 22 years who have been placed for non- educational reasons. These facilities include:

(i) child care facilities or institutions;

(ii) foster group homes;

(iii) therapeutic foster group homes;

(iv) habilitative foster group homes or agency group homes regulated by TDPRS;

(v) intermediate care facilities for the mentally retarded (ICFs-MR);

(vi) psychiatric treatment centers;

(vii) therapeutic camps or ranches;

(viii) residential treatment centers; and

(ix) nursing or convalescent homes.

(B) Students with disabilities are school-age (i.e., between the ages of birth and 22) individuals with "mental retardation; hearing impairments, including deafness; speech or language impairments; visual impairments (including blindness); serious emotional disturbance; orthopedic impairments; autism; traumatic brain injury; other health impairments; or specific learning disabilities; and who, by reason thereof, need special education and related services," pursuant to IDEA, 20 USC, §1401(a)(1)(A).

(b) Parties' responsibilities to students with disabilities residing in residential care facilities (RCFs).

(1) Texas Education Agency.

(A) The Texas Education Agency (TEA) is the state education agency (SEA). As an SEA, TEA is responsible for ensuring that a Free Appropriate Public Education (FAPE) is provided to all students with disabilities residing in the State of Texas and that all requirements of IDEA, Part B, are met, pursuant to 34 CFR, §300.600. A FAPE means special education and related services that are provided at public expense under public supervision; meet the state standards which include the requirements of IDEA, Part B; include preschool, elementary, and secondary school education; and are provided in conformity with an individual education plan, pursuant to 20 USC, §1401(a)(18).

(B) In most cases, local education agencies (LEAs), primarily independent school districts in Texas, have the direct responsibility of providing FAPE to students with disabilities whom the LEAs are obligated to serve under Texas Education Code, §25.001. The TEA is responsible for ensuring that LEAs comply with all state and federal requirements concerning the provision of FAPE.

(C) Within this general responsibility to assure FAPE, TEA specifically assures that each child with a disability, regardless of severity, residing within an LEA's jurisdiction will be identified, located, and evaluated in accordance with IDEA and its implementing regulations. To meet this responsibility, TEA requires LEAs to establish policies and procedures to identify, locate, and evaluate students with disabilities residing within their jurisdictions. Activities done pursuant to these policies and procedures are commonly referred to as "child find" activities because LEAs actively search for students with disabilities residing within their jurisdictions, often in coordination with regional education service centers and state agencies. These "child find" activities include searching for students with disabilities residing in RCFs.

(D) Before any student is placed in special education, a full and individualized evaluation is completed to determine eligibility and the nature of the disability.

(E) The local admission, review, and dismissal (ARD) committees are responsible for developing the individual educational plans (IEPs) of students with disabilities after considering the results of the evaluation. The TEA does not have the general authority to review or modify in any way the individual decisions of ARD committees made after following federal and state special education procedures. Parents, however, have procedural safeguards available to challenge decisions of ARD committees which include requesting due process hearings under 19 TAC Chapter 89, Subchapter AA, §§89.1151-89.1190, and filing complaints with the office responsible for special education complaints at TEA. Additionally, TEA has a regular monitoring system for reviewing LEA compliance with federal and state special education requirements.

(F) The TEA also specifically assures that each LEA in Texas will provide FAPE to students with disabilities in the least restrictive environment. When deciding what is the least restrictive environment for a student in an RCF, the ARD committee must base its decision on the individual needs of the student, not what is the most convenient arrangement for the school district or the RCF.

(G) The LEAs are responsible for implementing the IEP. The IEPs typically contain specified instructional and related services. Related services are intended to support the provision of special education services and are only provided when they are necessary for the student to benefit from special education instruction.

(H) Although TEA and LEAs are responsible for ensuring that all students with disabilities residing in Texas receive FAPE, this responsibility under IDEA and its implementing regulations does not:

(i) limit the responsibility of state agencies other than educational agencies for providing or paying for some or all of the costs of educating these students if obligated under another federal or state statutory or regulatory authority, pursuant to 34 CFR, §300.600(c); and

(ii) permit a state to reduce medical and other assistance available to children with disabilities, or alter the eligibility of a child with a disability under Title V (Maternal and Child Health) or Title XIX (Medicaid) to receive services that are also part of FAPE, pursuant to 34 CFR, §300.601.

(2) Texas Interagency Council on Early Childhood Intervention.

(A) The Texas Interagency Council on Early Childhood Intervention (ECI) is the lead agency under the Human Resources Code, Chapter 73, and the Individuals with Disabilities Education Act (IDEA), Part H, for early childhood intervention efforts for infants and toddlers with developmental delays or the potential for developmental delays between the ages of birth and three years. The ECI is governed by an interagency council composed of representatives from six health and human service agencies which provide some of the services needed by infants and toddlers who have developmental delays or the potential for developmental delays, and their parents, and three public members who are parents of children who have developmental delays. The council is responsible for the planning and implementation of a service system which benefits families with young children who are eligible for services under the Human Resources Code, Chapter 73, and IDEA, Part H.

(B) These services include providing assistance in dealing with variations in normal child development in one or more of the following areas:

(i) cognitive development;

(ii) physical development, including hearing and vision;

(iii) motor skills;

(iv) nutritional status;

(v) communications development;

(vi) social and emotional development; and

(vii) adaptive development and self-help skills.

(C) When infants and toddlers between birth and age three with developmental delays or the potential for developmental delays are discovered through the child find process in RCFs, they will be referred to LEAs by the RCFs and to an ECI-funded program by the LEAs for appropriate services. These services will be provided pursuant to the Human Resources Code, Chapter 73; IDEA, Part H; and existing MOUs between ECI and TEA.

(3) Texas Department of Human Services. The Texas Department of Human Services (TDHS) is responsible for the licensing, under the Texas Health and Safety Code, Chapter 242, and Medicaid certification, as the designated state survey agency, of the following long-term care facilities, which may include children as residents:

(A) Nursing facilities. Nursing facilities primarily provide skilled nursing care and related services, as well as rehabilitation services, to injured, disabled, or sick persons who reside in the facility.

(B) Intermediate care facilities for the mentally retarded (ICFs/MR). Intermediate care facilities for the mentally retarded provide institutional care and treatment for persons with mental retardation and persons with related conditions. These facilities range in size from small group homes to large state schools.

(4) Texas Department of Mental Health Mental Retardation.

(A) The Texas Department of Mental Health Mental Retardation (TDMHMR) is the state mental health and mental retardation authority and, as such, oversees the following residential programs that are six beds or greater and may serve students with disabilities as defined in this MOU.

(i) The intermediate care facilities/mental retardation or related conditions (ICF- MR/RC) Medicaid program provides residential and habilitation services to persons with mental retardation and to persons with a related condition. The TDMHMR is the operating agency for the ICF-MR/RC program, and the Health and Human Services Commission is the single state Medicaid agency. Providers who participate in this program have a contract with TDMHMR to deliver services under Title XIX of the Social Security Act (the Medicaid program).

(ii) The TDMHMR adopts rules and standards to ensure proper care and treatment of patients in private mental hospitals and mental health facilities required to obtain a license under the Texas Health and Safety Code, Chapter 577. All other licensing responsibilities for these facilities are performed by the Texas Department of Health.

(iii) The TDMHMR designates local mental health and mental retardation authorities in local service areas. A community mental health or mental retardation center, established under the Texas Health and Safety Code, Chapter 534, can be designated as a local mental health or mental retardation authority. The community center may own and operate residential services for students with disabilities, as defined in this MOU.

(B) The TDMHMR is authorized by law to provide mental health and mental retardation residential services to students with disabilities, as defined in the MOU, instate-operated facilities and community programs pursuant to the Texas Health and Safety Code, §§531.001 et seq.

(5) Texas Department of Health. The Texas Department of Health (TDH) is responsible for the following programs that may provide services to school-age residents of RCFs.

(A) Child health services. This program provides comprehensive health evaluations for infants, children, and adolescents, including health education, with emphasis on injury prevention, age-appropriate dietary patterns, normal child development, and

parenting skills. Services are provided by agency employees, contracts with local government providers, and contracts with private sector providers. The TDH is authorized to provide these services under Title V of the Social Security Act and the Maternal and Infant Health Improvement Act, the Health and Safety Code, Chapter 32.

(B) Texas medical assistance program (Medicaid) which includes the early and periodic screening, diagnosis, and treatment program (EPSDT). The EPSDT program provides comprehensive health care services that include preventive periodic screening, diagnosis, and treatment of medical and dental health problems to children eligible for Medicaid. Services are provided through fee-for-service billing by local government providers and private sector providers. The TDH is authorized to provide these services under the Social Security Act §§1902(a)(4)(B) and 1905(r).

(C) Medically dependent children program (MDCP). The MDCP provides in-home and out- of-home licensed nursing, facility-based respite care, and regular Medicaid state plan benefits. Services are provided through contracts with private sector providers. The TDH is authorized to provide these services under the Social Security Act, §19115(c).

(D) Children with special health care needs program (Chronically ill and disabled children's services (CIDC)). The CIDC provides case management, medical care, and related services for children with certain chronic illnesses or conditions. Services are provided by agency employees, through contracts with private sector providers and fee-for-service billing by private sector providers. The TDH is authorized to provide these services under Title V of the Social Security Act and the Chronically Ill and Disabled Children's Act, Chapter 35 of the Health and Safety Code.

(E) Vision and hearing screening program. This program provides training and certification for vision and hearing screeners to prevent eye injuries and preserve hearing. The services are provided by agency employees and through contract with private sector providers. The TDH is authorized to provide these services under the Special Senses and Communications Disorders Act, Chapter 36 of the Health and Safety Code.

(F) School health program. The school health program provides start-up funding for model school health centers to provide health, social, and mental health services for children and adolescents. Services are provided through grants to local government providers.

(G) Speech language screening program. The speech language screening program provides training and certification for speech/language screeners in identifying and referring children with communication delay. Services are provided by agency employees and through contracts with private sector providers. The TDH is authorized to provide these services under the Special Senses and Communication Disorders Act, under the Health and Safety Code, Chapter 36.

(H) Childhood lead prevention program. This program provides tracking and technical support for the professionals caring for children with positive EPSDT blood screening for lead. Services are provided by agency staff. The TDH is authorized to provide these services under the Social Security Act, §1905(r).

(I) Newborn screening program. This program provides testing at birth and two weeks of age for all children for five rare disorders to ensure early diagnosis and treatment. Services are provided by agency staff. The TDH is authorized to provide these services under the Phenylketonuria, Other Heritable Diseases, and Hypothyroidism Act, the Health and Safety Code, Chapter 33.

(J) Program for amplification for children in Texas (PACT). The PACT provides diagnostic evaluation of hearing impairments, hearing aid evaluations and hearing aids, and related hearing aid services. Services are provided through contracts with private sector providers and fee-for-service billing by private sector providers. The TDH is authorized to provide these services under the Special Senses and Communications Disorders Act, the Health and Safety Code, Chapter 36.

(K) Immunization program. This program provides vaccines for preventable diseases to all public and some private health care providers, tracks the incidence of immunization of preventable diseases, and investigates epidemics. Services are provided by TDH employees, through contracts with local government providers and through agreements with private sector providers. The TDH is authorized to provide these services under federal law by pursuant to 42 USC, 247b, and 42 CFR, 51b, Subparts A and B. The immunization program is authorized in state law under the Health and Safety Code, Chapters 81 and 161, and the Texas Education Code, §38.001.

(L) Spinal screening program. This program provides instructor and screener training and spinal screening to detect abnormal spine curvature in children attending public and private schools. The services are provided by agency employees. The TDH is authorized to provide these services under the Abnormal Spinal Curvature in Children Act, the Health and Safety Code, Chapter 37.

(6) Texas Department of Protective and Regulatory Services.

(A) The Texas Department of Protective and Regulatory Services (TDPRS), through its Child Care Licensing Division, is responsible for licensing the following entities that are RCFs for purposes of this MOU:

(i) foster group homes, including the following, under the authority of the Texas Human Resources Code, Chapter 42:

(I) primary medical care homes;

(II) habilitative homes;

(III) therapeutic homes;

(IV) homes serving children with autistic-like behavior; and

(V) basic care homes; and

(ii) twenty-four hour child care institutions, including the following, under the authority of the Texas Human Resources Code, Chapter 42:

(I) emergency shelters;

(II) residential treatment centers;

(III) institutions serving mentally retarded children;

(IV) institutions providing basic child care;

(V) halfway houses for children; and

(VI) therapeutic camps; and

(iii) maternity homes under the authority of the Texas Health and Safety Code, Chapter 249.

(B) The TDPRS, through its Protective Services to Families and Children (CPS) Division, is responsible for the following programs that provide services to children who may need special education.

(i) Children with disabilities projects are located in the Edinburg and Arlington areas and provide services to children with disabilities who are in the care of CPS or who have been referred to CPS because of being at-risk of child abuse or neglect. The TDPRS is authorized to provide services to these children under the Child Abuse Prevention and Treatment Act, 42 United States Code Annotated (USCA), §§5101-5106h.

(ii) Protective services to families and children program (CPS) provides services to all children, including children with disabilities, who have been or are at risk of being abused, neglected, or abandoned. Services may include investigation of alleged abuse or neglect, assessment, counseling, referrals to appropriate resources, family preservation services, and foster care. The TDPRS is authorized to perform these duties under the Texas Human Resources Code, Chapter 40; the Texas Family Code, Chapters 102, 153, 261-264; and Child Abuse Prevention and Treatment Act, 42 USCA, §§5101-5106h; and Titles IV-B and IV-E of the Social Security Act, 42 USCA, §§620-628 and §§670-679.

(7) Texas Youth Commission.

(A) The Texas Youth Commission (TYC) is the state juvenile correctional agency for youth who are committed to the TYC by local juvenile courts upon the youth's adjudication for delinquent conduct.

(B) The TYC places and funds RCFs through contracts for residential care for certain TYC youth. The TYC also certifies RCFs that take only TYC youth.

(C) The TYC halfway houses and those RCFs that are certified by TYC are required through TYC core standards to provide an educational component.

(D) The RCFs which contract with TYC are responsible for providing the educational component as required by TDPRS licensing standards based on the level of care they provide.

(E) All RCFs rely on LEAs to meet these licensing or core standards as provided in paragraph (1) of this subsection.

(8) Texas Juvenile Probation Commission. The Texas Juvenile Probation Commission (TJPC) is responsible for setting standards of operation and monitoring juvenile detention facilities and post- adjudication facilities. The TJPC also provides some funding to county operated juvenile probation departments, which may be used for placement of juvenile offenders in residential care facilities.

(9) Texas Commission on Alcohol and Drug Abuse. The Texas Commission on Alcohol and Drug Abuse (TCADA) licenses facilities (including residential facilities) that provide chemical dependency treatment for adolescents.

(c) Child find notification to local education agencies (LEAs).

(1) To further the assurances of TEA and LEAs to identify, locate, and evaluate students with disabilities residing in RCFs, the health and human services agencies agree to effectuate the following "child find" notification requirement: within three working days of admitting an individual between the ages of birth and 22 into a RCF for an educationally significant time period, the facility shall notify in writing the admittance of such an individual to the school district in which the RCF is located.

(2) To the extent authorized by existing federal and state laws, the health and human services agencies agree to adopt and implement policies and procedures requiring RCFs covered by this MOU to comply with the notification requirement as specified in subsection (c) of this section. These agencies further agree to have these policies and procedures in effect by September 1, 1996, to the extent possible, but no later than January 1, 1997.

(3) The TEA agrees to assist any of the health and human services agencies in the development and implementation of this "child find" notification requirement. The TEA further agrees to assist RCFs in identifying which school district should be given the "child find" notification specified in subsection (c) of this section.

(d) Sharing of information.

(1) The parties acknowledge that one vital component of interagency coordination with regard to the provision of special education services is the ability to share information between the parties and LEAs. Increasing this sharing should improve efficiency and minimize duplication of efforts. Given this acknowledgment, the parties agree to share all appropriate client and student records to the extent permitted by the applicable confidentiality statutes and regulations. Additionally, the parties agree to develop a "universal" consent form(s) by September 1, 1996, to facilitate this sharing of information.

(2) The parties also acknowledge that LEAs need the following information and/or records in order to determine the appropriate educational services for students with disabilities:

(A) birth certificate or another document as proof of the child's identity;

(B) medical history and medical records, including current immunization records;

(C) social history;

(D) vision and hearing screening and/or evaluation;

(E) assessment reports including psychological, educational, related service, and vocational assessments;

(F) RCF's treatment plan of care;

(G) educational history (at least previous educational placement to facilitate LEA's efforts to obtain educational records from previous LEA); and

(H) any court order which authorizes the placement in the RCF.

(3) Given this acknowledgment, the health and human services agencies agree to adopt and implement, to the extent permitted by existing federal and state laws, policies and procedures requiring RCFs to provide LEAs any of the information specified in paragraph (2) of this subsection and/or records available to the RCF within 14 working days of the school-age resident's admission to the RCF. These agencies further agree to have these policies and

procedures in effect by September 1, 1996, to the extent possible, but no later than January 1, 1997.

(4) To the extent permitted by the Family Educational Privacy Rights Act, 20 USC, §1232g, and its implementing regulations, 34 CFR, Part 99, TEA assures that LEAs will provide available educational records requested by RCFs within 14 working days.

(e) Educational space.

(1) The parties acknowledge that all students with disabilities are entitled to be educated in the least restrictive environment (LRE) in accordance with the requirements of IDEA and its implementing regulations. The parties further acknowledge that many RCF placements are made primarily for non-educational reasons, such as for treatment or juvenile justice considerations. Nevertheless, TEA and LEAs must assure that the LRE requirements are met for these placements.

(2) Under IDEA, ARD committees are charged with the responsibility of deciding what is the appropriate educational placement for individual students with disabilities, including school-age residents of RCFs. In making this decision, ARD committees must consider the non-educational needs of these students that restrict the ability of school districts to serve these students on campus in a less restrictive environment. These needs include the student's health and safety needs (e.g., medically fragile), the student's placement in a restrictive RCF program (e.g., juvenile incarceration), and the student's participation in intensive care and treatment (e.g., intensive substance abuse treatment). The ARD committees' decision process must be individualized and not done on a categorical basis, such as the category of the student's disability or residence in a RCF. Further, ARD committees cannot determine educational placement on the basis of what is most convenient to school districts or RCFs.

(3) The TEA assures that, before making these decisions, ARD committees will consider:

(A) the care and treatment plan;

(B) the nature or conditions of the RCF program;

(C) the RCF's preference as to where the student should be educated in light of the student's care and treatment needs and the RCF program; and

(D) the RCF's description of available space should the student need to be educated at the RCF.

(4) The ARD committees are also charged with the responsibility of determining whether space available at the RCF is adequate for the education of individual students for whom the ARD committee is considering educational placement at the RCF. This determination must be based on the individual student's needs and the RCF's description of available space.

(5) If the ARD committee decides that the space described by the RCF is not adequate for the education of the individual student in question or the RCF has no available space, the ARD committee shall find alternative locations for providing educational services. If the LEA disputes the accuracy of the RCF's description of available space, the LEA may use the dispute resolution procedures specified in subsection (h) of this section.

(6) If the RCF subsequently decides to eliminate or reduce space it has previously described to the LEA as being available for one or more individuals, the RCF shall notify the LEA immediately. If the RCF determines that the space it is currently making available to the LEA will no longer be available for one or more individuals or must be reduced, the RCF shall notify the LEA at least 30 days with regard to an individual student or 90 days if the RCF decision impacts more than one student prior to taking any action regarding this space.

(7) The notice requirements specified in paragraph (6) of this subsection are not applicable to those situations where an RCF must interrupt or terminate a school district's use of space due to regulatory actions beyond the RCF's control (e.g., an order to immediately receive additional clients because of an emergency occurring in another RCF).

(8) In those instances where the ARD committee decides that the RCF is the appropriate educational placement consistent with the RCF's preference and the ARD committee determines that the available space described by the RCF is adequate, the RCF is required to:

(A) assure that the space described by the RCF prior to the ARD committee's decision to place the student at the RCF will be provided; and

(B) not charge LEAs any of the costs related to this space which include the costs incurred for the operation and maintenance of this space.

(9) In those instances where the ARD committee decides that the RCF is the appropriate educational placement and the RCF has recommended a preference for not educating the student at the RCF and the ARD committee decides that the available space described by the RCF is adequate, the RCF is required to provide the described space. If the RCF seeks to charge a LEA for this space and these two entities cannot reach an amicable resolution of this matter, the dispute resolution procedures as provided in subsection (h) of this section must be used.

(10) The requirements specified in subsection (e) of this section do not abrogate the responsibility of LEAs to provide the educational and related services set out in the individual educational plan (IEP). Nor do these requirements create a duty on RCFs to construct space if adequate space does not exist in the RCF for educating its residents.

(11) To the extent authorized by existing federal and state law, the health and human services agencies agree to adopt policies and procedures to implement the requirements specified in subsection (e) of this section by September 1, 1996, to the extent possible, but no later than January 1, 1997.

(12) The parties agree to coordinate their regulatory and planning functions with regard to the licensure, certification, and funding of RCF placements involving school-age residents with disabilities to further assure that adequate space will be available for educating those students who cannot be served on a school campus because of their non-educational needs.

(f) Impact of residential care facilities (RCFs) on local education agencies (LEAs).

(1) The parties acknowledge that LEAs are impacted in their ability to provide special education services when a new RCF opens up or expands which serves school-age residents. This impact may be substantial especially in situations where the LEA is small and located in a rural setting.

(2) Given this acknowledgment, the parties agree to develop the following with regard to contracting, licensing, or certifying entities that seek to establish or expand RCFs which serve or plan to serve school-age residents:

(A) State agency coordination. The parties agree to coordinate their regulatory and planning functions and collaborate on assessment, planning, and use of specialists to ensure that education and treatment resources are efficiently and effectively used to appropriately serve students with disabilities in supportive, integrated and least restrictive environments.

(B) Notification to the local education agency (LEA). Any entity requesting to establish a new RCF or expand a RCF that serves or plans to serve school-age residents will be required to provide prior written notice to the affected LEA of their intent to establish or expand a RCF within the LEA's boundaries. This notice must be given within a reasonable time period so that the LEA can plan accordingly. To the extent permissible under current law, the health and human services agencies agree to establish policies and procedures for this notification requirement by September 1, 1996, to the extent possible, but no later than January 1, 1997. The TEA agrees to assist the health and human service agencies in the development and implementation of the policies and procedures.

(g) Parental participation.

(1) The parties acknowledge that parental participation is essential for the determination and the provision of appropriate special education services under IDEA. However, many of the school- age residents placed in RCFs are under the conservatorship of the State of Texas (usually through TDPRS). For these residents, the parties acknowledge the following "surrogate parent" requirements:

(A) The LEAs have the obligation to ensure that a properly trained surrogate parent with no conflicts of interest is appointed for these residents for whom:

(i) no parent can be identified;

(ii) the parent cannot be located after reasonable efforts by the LEA to locate; or

(iii) are wards of the state (e.g., in Texas, the term "conservatorship" is often used to indicate a student is a ward of the state, pursuant to 34 CFR, §300.514(a)).

(B) The LEAs decide as to when and whom to appoint as surrogate parents.

(C) The appointment of a surrogate parent is not restricted to circumstances in which parental rights have been formally terminated by a court. In fact, the requirement to appoint a surrogate parent will be triggered by placing a child under the temporary or permanent conservatorship of the state.

(D) The appointment of a surrogate parent does not necessarily terminate parental rights under IDEA. Unless parental rights have been terminated under the Texas Family Code, parents do not lose their rights to participate in the educational process of their children as the result of the appointment of a surrogate parent.

(E) The obligation to appoint a surrogate parent is not necessarily eliminated when a student turns 18 years old. In some instances, a surrogate parent can be appointed for a student with a disability who is between 18 and 22 years old if needed to assure that this student receives FAPE.

(F) The surrogate parent appointed must have the knowledge and skills to ensure adequate representation of the child and no personal or professional interest which would create a conflict of interest in his or her representation of the child, pursuant to 34 CFR, §300.514(c).

(G) Pursuant to 34 CFR, §300.514(c), a person assigned as a surrogate parent may not be an employee of a public agency that is involved in the education or care of the child. Thus, public (state, county, or local) employees, like caseworkers or probation officers, would be ineligible to serve as surrogate parents.

(H) Directors and employees of private RCFs generally cannot serve as surrogate parents because of a conflict of interest.

(I) Pursuant to 34 CFR, §300.514(e), surrogate parents may represent the child in all matters relating to:

(i) the identification, evaluation, and educational placement of the child; and

(ii) the provision of FAPE to the child.

(2) The TEA assures that in those cases where a surrogate parent is appointed, state caseworkers and the appropriate RCF personnel will be given an opportunity to discuss the student's educational needs with the surrogate parent prior to ARD committee meetings, or at a mutually agreeable time. The TEA further assures that the caseworker representing the state agency having conservatorship of the student and the appropriate RCF representative may participate in the deliberations of the ARD committee, but in no circumstance in place of the required surrogate parent or make the decisions belonging to the surrogate parent.

(h) Dispute resolution.

(1) Intra-agency disputes. Intra-agency disputes concerning the implementation of the MOU shall be resolved in accordance with that agency's established policies and procedures.

(2) Inter-agency disputes.

(A) Disputes concerning implementation of this MOU between either agencies that are parties to the MOU or a local education agency and a party to this MOU, should first be resolved at the local level. The specific issues involved in the dispute and possible solutions shall be identified and referred to the local officials authorized to make the decisions necessary to resolve the dispute.

(B) If local resolution is not possible after a reasonable time period, the inter-agency dispute should be referred to the executive officers of the respective state agencies for further negotiations towards a mutually agreeable resolution. Local agencies submitting to the state agency level shall identify the:

(i) nature of the dispute;

(ii) resolutions agreed upon at the local level;

(iii) issues that remain unresolved at the local level; and

(iv) local contact person(s).

(C) The appropriate state officials shall meet to seek resolution of the dispute.

(D) If resolution is not possible at the state level, the executive officers may pursue resolution through the use of mediation

or refer the local parties to mediation. As defined in the Texas Civil Practices & Remedies Code, §154.023, "ediation is a forum in which an impartial person, the mediator, facilitates communication between parties to promote reconciliation, settlement, or understanding among them." The parties should mutually agree on an impartial third party to serve as the mediator, as well as the procedures for conducting the mediation. The mediation shall be non-binding unless the parties agree otherwise.

(i) Contact persons. The following are the contact persons for the respective parties to whom questions or concerns may be directed with regard to this MOU and its implementation.

(1) Texas Education Agency (TEA), director of interagency coordination, 1701 North Congress Avenue, Austin, Texas 78701, (512) 463-9283.

(2) Texas Department of Human Services (TDHS), assistant deputy commissioner for long term care, 701 West 51st Street, Austin, Texas 78751, (512) 438-3011.

(3) Texas Department of Mental Health and Mental Retardation (TDMHMR), Managed Care Division Children Services, P. O. Box 12668, Austin, Texas 78711, (512) 206-4830.

(4) Texas Department of Health (TDH), director, Children's Health Division, Bureau of Women and Children, 1100 West 49th Street, Austin, Texas 78756-3199, (512) 458-7355, extension 3104.

(5) Texas Department of Protective and Regulatory Services (TDPRS), staff attorney for programs, 701 West 51st Street, Austin, Texas 78751, (512) 438-3803.

(6) Texas Interagency Council on Early Childhood Intervention (ECI), deputy director, 1100 West 49th Street, Austin, Texas 78756-3199, (512) 502-4900.

(7) Texas Commission on Alcohol and Drug Abuse (TCADA), general counsel, 9001 North IH-35, Suite 105, Austin, Texas 78753-5233, (512) 349-6615.

(8) Texas Juvenile Probation Commission (TJPC), general counsel, P.O. Box 13547, Austin, Texas 78711, (512) 443-2001.

(9) Texas Youth Commission (TYC), chief of community placement, P.O. Box 4260, Austin, Texas 78751, (512) 483-5093.

(j) Other terms.

(1) This MOU shall be signed by the executive officers of the participating agencies and shall be effective upon signature by all.

(2) This MOU shall be adopted by rule prior to January 1, 1997.

(3) This MOU may be considered for expansion, modification, or amendment upon mutual agreement of the executive officers of the participating agencies.

(4) In the event that federal and/or state laws should be amended, federally interpreted, or judicially interpreted so as to render continued implementation of this MOU unreasonable or impossible, the participating agencies may agree to amend or terminate this MOU.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 29, 1997.

TRD-9701366
Criss Cloudt
Associate Commissioner, Policy Planning and Research
Texas Education Agency
Effective date: February 19, 1997
Proposal publication date: November 22, 1996
For further information, please call: (512) 463–9701

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Chapter 161. Advisory Committees

Subchapter AA. Commissioner's Rules

19 TAC §§161.1001–161.1003

The Texas Education Agency (TEA) adopts an amendment to §161.1001-161.1003, concerning advisory committees, without changes to the proposed text as published in the November 15, 1996, issue of the *Texas Register* (21 TexReg 11156). The sections provide guidelines for establishing and operating advisory committees and a list of public education advisory committees in effect. The amendments are necessary to conform with the Texas Education Code, Texas Education Agency (TEA) operating procedures and the Comptroller of Public Accounts approval of the current TEA advisory committee list.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Education Code, §7.055(a)(11), which authorizes the commissioner of education to appoint advisory committees as necessary to advise the commissioner in carrying out the duties of the TEA.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 29, 1997.

TRD-9701367
Criss Cloudt
Associate Commissioner, Policy Planning and Research
Texas Education Agency
Effective date: February 19, 1997
Proposal publication date: November 15, 1996
For further information, please call: (512) 463–9701

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TITLE 22. EXAMINING BOARDS

Part VI. Texas State Board of Registration for Professional Engineers

Chapter 131. Practice and Procedure

Examinations

22 TAC §131.101

The Texas State Board of Registration for Professional Engineers adopts an amendment to §131.101, concerning engineering examinations required for registration as a professional engineer, without changes to the proposed text as published in the November 12, 1996, issue of the *Texas Register* (21 TexReg 11041).

The amendment redefines when a student is considered to be a senior in college for the purpose of scheduling the fundamentals of engineering examination.

The rule provides clarification that an undergraduate student who is within two regular semesters (not including summer sessions) of graduating is considered a senior and may take the fundamentals of engineering examination.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 3271a, §8(a), which provide the board with the authority to make and enforce all rules and regulations necessary for the performance of its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701385
John R. Speed, P.E.
Executive Director
Texas State Board of Registration for Professional Engineers
Effective date: February 20, 1997
Proposal publication date: November 12, 1996
For further information, please call: (512) 440-7723

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Professional Conduct and Ethics

22 TAC §131.155

The Texas State Board of Registration for Professional Engineers adopts an amendment to §131.155, concerning professional practice and reputation, without changes to the proposed text as published in the November 12, 1996, issue of the *Texas Register* (21 TexReg 11042).

The amendment was necessary to remove the legal action of making a political contribution from the list of illegal actions otherwise described in subsection (a) and to correct the legal reference to the Texas Professional Services Procurement Act from the civil statute to the government code in subsection (d).

The rule eliminates the legal right of making political contributions from the list of illegal actions and provides the correct legal reference to the Texas Professional Services Procurement Act.

No comments were received regarding adoption of the amendment.

The amendment is adopted under Texas Civil Statutes, Article 3271a, §8(a), which provide the board with the authority to make and enforce all rules and regulations necessary for the performance of its duties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701386
John R. Speed, P.E.
Executive Director
Texas State Board of Registration for Professional Engineers
Effective date: February 20, 1997
Proposal publication date: November 12, 1996
For further information, please call: (512) 440-7723

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TITLE 25. HEALTH SERVICES

Part II. Texas Department of Mental Health and Mental Retardation

Chapter 401. System Administration

Subchapter A. Advisory Committees

§§401.4-401.7, 401.13, 401.15, 401.19, 401.20, 401.22

The Texas Department of Mental Health and Mental Retardation (TDMHMR) adopts amendments to §§401.4-401.7, 401.13, 401.15, 401.19, 401.20, and 401.22, concerning advisory committees, without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11935).

The amendments reflect the Texas Board of Mental Health and Mental Retardation's resolution to authorize the continuation of the advisory committees through January 1, 2001, unless abolished on an earlier date or reauthorized.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the Texas Health and Safety Code, Title 7, §532.015, which provides the Texas Board of Mental Health and Mental Retardation with rulemaking powers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701417
Ann Utley
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Effective date: February 21, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 206-4516

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25 TAC §401.11

The Texas Department of Mental Health and Mental Retardation (TDMHMR) adopts the repeal of §401.11, concerning advisory committees, without changes to the proposed text as published in the December 13, 1996, issue of the *Texas Register* (21 TexReg 11936).

The adoption abolishes the MI/Deaf Advisory Committee because it accomplished its purpose in August 1995.

No comments were received regarding adoption of the repeal.

The repeal is adopted under the Texas Health and Safety Code, Title 7, 532.015, which provides the Texas Board of Mental Health and Mental Retardation with rulemaking powers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701416
Ann Utley
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Effective date: February 21, 1997
Proposal publication date: December 13, 1996
For further information, please call: (512) 206-4516

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Chapter 408. Standards and Quality Assurance

Subchapter E. Health, Safety and Rights in Community-based Mental Retardation Programs

25 TAC §§408.151- 408.164

The Texas Department of Mental Health and Mental Retardation (TDMHMR) adopts new §§4081.151-408.164. Sections 408.152-408.159 and 408.163, concerning health, safety, and rights in community-based mental retardation programs are adopted with changes to the text as proposed in the September 20, 1996, issue of the *Texas Register* (21 TexReg 9038). Sections 408.151, 408.160-408.162, and 408.164 are adopted without changes and will not be republished.

The new sections describe minimum health, safety, and rights standards necessary to ensure the protection of individuals receiving mental retardation supports and services in community-based programs. These standards will be applied within the scope of the Quality Assurance and Improvement System (QAIS) as described in Chapter 408, Subchapter C, governing quality assurance and improvement system (QAIS) for mental retardation services and supports. The standards set forth in the rule are intended to replace the 1988 TDMHMR Community Standards for Individuals with Mental Retardation which are adopted by reference in Chapter 408, Subchapter A, governing standards of the Texas Department of Mental Health and Mental Retardation – Quality Assurance.

In §408.153, the definition of designated provider has been revised to reference a local mental retardation authority rather than just local authority. The definition of interdisciplinary team has been amended to reflect the principle of person-centered planning by stating that the team is determined by the individual or LAR and identified by the organization. The term "psychotropic" in the definition of polypharmacy has been changed to "psychoactive" for consistency. The term "restraint, physical" has been revised to "restraint" for consistency with the term as used in the text of the sections.

In §408.154(d) the language is revised to clarify that the organization must have written policies and procedures. In subsection (c) of the same section, the term "service plan" is substituted for "habilitation plan" to reflect a more extensive array of services and supports than the more traditional habilitation services. In subsection (d) of the same section, language has been revised to require an organization to develop and implement procedures for dealing with allegations of abuse, neglect, and exploitation, as well as allegations of rights violations. In addition, a reference to the department's rule on the rights of persons receiving mental retardation services has been added.

In §408.155, language has added requiring the organization to maintain documentation of the type and content of training, along with attendance records.

In §408.156, supervision of self-administration of medication has been added to the listing of elements to be addressed in the organization's written policies and procedures.

An incorrect reference in §408.157(c)(6) to tests for acquired immune deficiency syndrome (AIDS) has been corrected to specify that tests will be conducted for the human immunodeficiency virus (HIV).

Language in §408.158(a) has been clarified to reflect that approved interventions for behavior management programs could include aversive techniques and procedures, and that these must be addressed in the organization's written policies and procedures. In subsections (b) and (d) of the same section, the term "intrusive" has been included to be consistent with language in subsection (a). In subsection (c), the misspelling of "threat" has been corrected. Clarifying language has been added in subsection (d) specifying that the control of the symptoms of mental illness may be achieved through restrictive or intrusive interventions; the proposed language implied that mental illness could be eliminated through the use of such interventions. In subsection (g), the reference to "drug therapies" has been deleted in the parenthetical phrase. The second sentence of the stem of subsection (h) has been deleted as contradictory. In subsection (h)(1), the term "capacity" has been replaced with the phrase "inability to provide legally adequate consent" in keeping with the department's current use of terminology.

In §408.159(1), clarification has been added that the rationale for the use of psychoactive medications must include a current DSM diagnosis. Also in that paragraph, the department has clarified that the individual's quality of life, and not the service plan, should be the focus when considering the impact of a psychoactive medications. In paragraphs (4) and (6), language has been added to specify that the individual with the ability to provide legally adequate consent or the LAR may provide or withdraw consent.

In §408.163, the department's rule on abuse, neglect and exploitation in community- based programs has been added to the list of referenced documents.

A public hearing was held in Austin on November 1, 1996. No members of the public offered testimony. Written comments were received from the following members of the public: Austin-Travis County MHMR, Austin; Dallas County MHMR, Dallas; Lubbock Regional MHMR Center, Lubbock; Permian Basin Community Centers, Midland; and Tarrant County MHMR Services, Fort Worth.

Three commenters suggested that the definition of interdisciplinary team in §408.153 was prescriptive and inconsistent with the principles of person-centered planning. The department has revised the definition. Another commenter suggested that having a member of a mental retardation authority's public responsibility committee (PRC) included on the IDT was of doubtful value. The department responds that the option of including an PRC member is required by law, and explains that the inclusion is not automatic. The individual with the ability to provide legally adequate consent or the LAR may request participation by a member of the PRC or, if the individual is unable to provide legally adequate consent and does not have an LAR, the PRC may request that a PRC member participate.

A commenter suggested that the supervision of self-administration of psychoactive medications should be addressed in an organization's written policies and procedures. The department agrees with the suggestion and has modified §408.156(a).

A commenter requested clarification in §408.157 concerning who should be tested for HIV and hepatitis B. The department has clarified that the organization is to specify in its written policies and procedures the criteria to be followed for determining when an individual served by the organization should be tested for HIV and hepatitis B.

A commenter requested clarification of the "accepted standards of professional practice" referenced in §408.158. The department responds that "accepted standards" could include, but not necessarily be limited to, guidelines promulgated by the Texas State Board of Examiners of Psychologists and or the Texas Board of Medical Examiners or by national accreditation associations. If the organization is unsure of whether the standards and procedures they propose to follow are acceptable, appropriate professional staff in Central Office may be consulted.

A commenter questioned whether the language in §408.158(h) is intended to require that written informed consent be obtained for the use of physical interventions prescribed in the department's Prevention and Management of Aggressive Behavior curriculum. The department has revised the language to specify that only when physical interventions are used as part of a behavior management program does informed consent need to be obtained.

A commenter asked whether the surrogate decisionmaking process referenced in §408.158(h)(1) was being expanded to apply to community-based residential programs other than ICF/MR. The department responds that only the legislature has the authority to expand the program beyond community-based ICF/MRs. The statutory authority for the program is to be considered by the legislature during the 75th Legislative Session; unless reauthorized, the program will be discontinued in August 1997.

A commenter questioned what constitutes "assistance" to a person who will be entering the service delivery system when that person is not admitted to direct services operated by or contracted for by the organization. The department responds that "assistance" would include, at a minimum, a good faith effort to provide information about service and support providers appropriate to meet the needs of that individual.

These sections are adopted under the Texas Health and Safety Code, §532.015, which provides the Texas Mental Health and Mental Retardation Board with broad rulemaking authority, and §534.052, which gives the board rulemaking authority for community-based mental health and mental retardation services provided by community centers and other contract providers.

§408.152. Application.

This subchapter applies to community-based mental retardation services and supports funded by the department and delivered by:

(1) local mental retardation authorities (including both community centers and state operated community MHMR services) and the providers with which they contract; and

(2) designated providers.

§408.153. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

AIDS – Acquired immune deficiency syndrome as defined by the National Centers for Disease Control and Prevention of the U.S. Public Health Service.

Actively involved – Involvement with the individual which the IDT deems to be of a quality nature based on the following:

(A) observed interactions of the person with the individual;

(B) advocacy for the best interests of the individual;

(C) knowledge of and sensitivity to the individual's preferences, values, and beliefs;

(D) ability to communicate with the individual; and

(E) availability to the individual for assistance or support when needed.

Behavior management – All efforts to increase socially adaptive behavior and to modify maladaptive or problem behaviors and replace them with behaviors and skills that are adaptive and socially productive. This broad category includes behavior interventions, emergency procedures used to protect an individual or other persons due to the actions of that individual, and both formal and informal planned interactions intended to increase socially adaptive behavior and/or to modify maladaptive or problem behaviors.

Community center – A community mental health and mental retardation center established under the Texas Health and Safety Code, Title 7, Chapter 534.

Designated provider– As defined in the Texas Health and Safety Code, §534.054(c), a service provider with whom the department contracts for the delivery of a specific community-based mental retardation support or service in a specified local service area of the

state if the MRA for that local service area is unable or unwilling to provide that service. The term does not include a local mental retardation authority.

Emergency care – Procedures and intervention designed to respond to medical emergencies.

Hepatitis B – An infection of the liver caused by the hepatitis B virus (HBV).

Hepatitis B immunization – Vaccination of persons at risk of infection from HBV.

Hepatitis B testing– Blood test for detection of hepatitis B surface antigens and antibodies.

HIV – Human immunodeficiency virus.

HIV testing – Blood test for detection of human immunodeficiency virus infection.

HC (human rights committee) – A committee appointed by the MRA comprising an independent group of representatives with the delegated authority to ensure that the civil and legal rights of individuals receiving services are acknowledged, respected, and protected through the review of organizational practices and approaches. The HC is a mechanism for ensuring due process. Members of the human rights committee include, but are not limited to, individuals served by the MRA or designated provider, their legally authorized representatives, local advocates, and persons from the community who are not affiliated with the MRA or designated provider.

(A) Minimally, one committee member should be experienced in issues and decisions regarding human rights.

(B) At least one third of the members should not be affiliated with the MRA or designated provider.

(C) Any member directly involved in the development, review, or approval of a proposal before the committee will not take part in deliberations relative to that proposal.

(D) Members should receive appropriate training to maximize the benefit of their participation on the committee.

Interdisciplinary team (IDT) – Mental retardation professionals and paraprofessionals and other concerned persons, as appropriate, who assess the individual's treatment, training, and service plan needs and make recommendations for services. This team, as determined by the individual or LAR and identified by the MRA or designated provider includes:

(A) the individual;

(B) the legally authorized representative of an individual who has been adjudicated by a court as lacking legal capacity;

(C) at the invitation of the individual with the ability to provide legally adequate consent or the legally authorized representative, family members or other persons who are actively involved in the life of the individual;

(D) persons who are professionally qualified, certified, or both, in various professions with special training and experience in the diagnosis, management, needs, and treatment of individuals with mental retardation;

(E) persons who are directly involved in the delivery of mental retardation services to the individual; and

(F) member(s) of the local authority's public responsibility committee (PRC), if requested by the individual with the ability to provide legally adequate consent, a legally authorized representative, or the PRC in instances when the individual does not have either the ability to provide legally adequate consent or an LAR.

Informed consent (legally adequate consent) – A term consistent with provisions of the Texas Health and Safety Code, §591.006, concerning consent obtained from an individual with mental retardation which is legally adequate when each of the following conditions has been met:

(A) legal status: The individual giving the consent is of the minimum legal age and currently does not have a guardian appointed to manage personal affairs by an appropriate court of law;

(B) comprehension of information: The individual giving the consent has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of and alternatives to the procedure, and the fact that withholding or withdrawal of consent shall not prejudice the future provision of care and services to the individual with mental retardation; and

(C) voluntariness: The consent has been given voluntarily and free from coercion and undue influence.

Legally authorized representative – The parent of an individual who is a minor, the guardian of an individual who has been determined by a court to lack capacity, or the managing conservator of an individual.

MRA (mental retardation authority) – As defined in the Texas Health and Safety Code, §531.002, an entity to which the Texas Mental Health and Mental Retardation Board delegates its authority and responsibility within a specified region for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental retardation services to individuals with mental retardation in one or more local service areas. An MRA can be either a community center or a state-operated community MHMR services division.

Medication administration – The direct application of a drug by injection, inhalation, ingestion, topical application or any other means to the body of a person in accord with the Texas Medical Practice Act.

Polypharmacy – Simultaneous use of more than one psychoactive from the same medication class to treat an individual. The period of overlapping use of more than one psychoactive medication when a physician changes an individual from one drug to another shall not be considered polypharmacy.

Psychoactive medication – Any medication which is prescribed for the primary intent of, improving cognition, affective state, and/or behavior.

Restraint – Refers to the use of personal restraint methods or mechanical devices that are intended to restrict the movement or normal functioning of a portion of an individual's body.

State operated community-based MHMR services division – Those entities which provide community-based mental health and/or mental retardation services and which are operated by the department. Formerly known as community-based service divisions of state facilities.

Tardive dyskinesia – A possible side effect of neuroleptic medication characterized by involuntary and abnormal movements which are purposeless and stereotypical.

Tuberculosis – A disease spread through airborne particles containing tubercle bacilli which become established in the lungs and may spread throughout the body.

§408.154. Encouraging Full Expression of Individual Rights.

(a) The MRA or designated provider will encourage the full expression of legal and civil rights by each individual receiving services and will provide supports, as necessary, to assist individuals and their legally authorized representatives in the exercise of their rights. The MRA or designated provider will fully inform individuals and their legally authorized representatives of their rights as guaranteed under the Persons with Mental Retardation Act (Texas Health and Safety Code, Title 7, Subtitle D). In doing so, the MRA or designated provider will refer to Chapter 405, Subchapter Y of this title (relating to Client Rights – Mental Retardation Services) and use the handbook prescribed in the subchapter.

(b) The MRA or designated provider shall ensure that due process is provided when an individual's rights must be limited. (As applicable, see Chapter 405, Subchapter J of this title (relating to Surrogate Decision-Making for Community-Based ICF/MR and ICF/MR/RC Facilities).) Due process includes:

(1) obtaining informed consent in writing for a period not to exceed one year from the individual or the legally authorized representative; and

(2) review by the IDT and, if appropriate, the human rights committee of the proposed limitation of the individual's rights.

(c) When an individual's rights must be limited, the IDT will consider what, if any, training or modifications to the individual's service plan might enable the limitations to be removed.

(d) The MRA or designated provider shall develop and implement written policies and procedures for reporting and investigating allegations of rights violations and allegations of abuse, neglect, and exploitation, and taking appropriate action in confirmed cases. See Chapter 405, Subchapter Y of this title (relating to Client Rights Mental Retardation Services) and Chapter 404, Subchapter B of this title (relating to Abuse, Neglect, and Exploitation of People Served by Providers of Local Authorities).

(e) Procedures for appeal of decisions shall be delineated and publicized, and shall include a mechanism for external review or mediation if agreement can not be reached. For MRAs, these procedures will include those set forth in §401.464 of this title (relating to Notification and Appeals Process). See Chapter 401, Subchapter G of this title (relating to Community Mental Health and Mental Retardation Centers.)

§408.155. Human Resources.

The MRA or designated provider ensures that:

(1) all staff possess the work experience and education/credentials required by the job description or contract;

(2) verification of credentials and verification of the renewal of credentials is maintained in the human resource file for all certified or licensed professionals;

(3) professional personnel are licensed, certified, or registered, if required by law;

(4) there is a mechanism in place for maintaining and ensuring standards of professional and ethical practice;

(5) staff have the necessary training and demonstrate the necessary skills to ensure that the health, safety, and support needs of individuals are met ; and

(6) documentation is maintained of the type and content of training and attendance records.

§408.156. Medication Practice and Health Related Services.

(a) The MRA or designated provider operates in accordance with accepted principles of practice and applicable federal and state laws and regulations to ensure medication is administered safely and appropriately. The written policies and procedures of the MRA or designated provider shall address:

(1) proper handling, storage, and disposal of medications;

(2) proper use of telephone orders;

(3) administration of medications by staff licensed or authorized to administer medications;

(4) supervision of self-administration;

(5) administration of medications without errors; and

(6) documentation of follow up and corrective action when medication errors do occur.

(b) Each individual receives preventive and timely health care services based on health needs and condition.

(c) The MRA or designated provider ensures the availability of physician, dental, nursing, pharmacy, and laboratory services by qualified personnel, in compliance with laws and regulations, based on each individual's needs, and provides for emergency care during hours of program operation.

(d) The MRA or designated provider has written policies and procedures which address the use of physical restraints and psychoactive medication when necessary during a medical or dental procedure or to promote healing following a medical procedure or an injury. The policies and procedures shall address appropriate documentation including:

(1) medical necessity;

(2) the behavior to be controlled;

(3) a physician's or dentist's written order;

(4) renewals, if necessary, every 12 hours; and

(5) provision of appropriate medical treatment and observation.

§408.157. Infection Control.

(a) In accordance with recommendations of The Centers For Disease Control and Prevention and the Occupational Safety and Health Administration, the MRA or designated provider shall ensure that an infection control plan is in place to decrease the risk for infection and/or transmission of diseases.

(b) Documentation shall be included in the MRA's records that the plan has been implemented.

(c) The plan addresses the following:

(1) orientation training and updates;

(2) prevention and management of infections for staff/providers and individuals (to include, but not be limited to, HIV, hepatitis B, and tuberculosis);

(3) postexposure treatment for consumers and staff;

(4) procedures for reporting of reportable diseases to the Texas Department of Health (TDH);

(5) personnel policies in compliance with state and federal law;

(6) criteria for determining when a consumer should be tested for HIV and hepatitis B;

(7) hepatitis B immunization; and

(8) special waste disposal as required by TDH as described in 25 TAC §§1.131-1.137 (relating to Definition, Treatment, and Disposition of Special Waste from Health Care).

§408.158. Behavior Management.

(a) The MRA or designated provider has written policies and procedures addressing behavior management which:

(1) specify all approved interventions including aversive procedures and techniques;

(2) designate a hierarchy of intervention from most positive and least intrusive to most restrictive and intrusive; and

(3) specify accepted standards of professional practice for the use of these interventions.

(b) Restrictive and/or intrusive interventions (i.e., physical restraint, time-out, or psychoactive medications) are used only when warranted by the severity of the behavior, based on a functional analysis and team input, and result in desired behavioral outcomes.

(c) The emergency use of restrictive interventions occurs when the behavior is not predictable and presents the clear threat of injury to self or others. If emergency interventions are needed more than twice during two consecutive months a functional analysis is undertaken to develop a program to reduce the frequency and severity of the identified behaviors.

(d) Restrictive and/or intrusive interventions may be used as part of an individualized plan that is intended to lead to less restrictive means of managing and eliminating the behavior or controlling the symptoms of mental illness.

(e) Monitoring of the individual during all restrictive interventions is at the appropriate level for the type of intervention being used and assures that individual rights are protected.

(f) All restrictive interventions addressing the management of targeted behavior are justified by the functional assessment, the current level of behavior, and are reviewed by the treatment team at least annually to determine the ongoing need and to assess for the possible decrease in the use of the intervention, based on current clinical evidence. When possible, the acquisition of adaptive replacement behaviors are also measured.

(g) Non-contingent interventions (i.e. environmental engineering, counseling, etc.) are similarly evaluated for their effectiveness through the use of individualized and quantified measures.

(h) Except in an emergency, written informed consent for a period not to exceed one year is obtained when restrictive and/or intrusive interventions are included as part of a behavior management program.

(1) The Human Rights Committee should review the situation carefully as a matter of due process. When the failure to obtain written informed consent is based on the individual's assessed inability to provide legally adequate consent, the need for obtaining a guardian should be considered. When applicable, surrogate decision making will be considered as described in Chapter 405, Subchapter J of this title (relating to Surrogate Decision-Making for Community-Based ICF/MR and ICF/MR/RC Facilities.)

(2) The individual or guardian have the right to withdraw consent to treatment at any time without regard to any time limit specified in the consent form.

(3) People do not have the right to cause injury to self or others, but the individual does have a right to be free of unnecessary drugs and other restrictive interventions and to receive appropriate treatment. This can best be ascertained when planned interventions are evaluated and determined to be effective.

§408.159. Psychoactive Medications.

In accordance with accepted principles of practice, the MRA or designated provider shall ensure that:

(1) psychoactive medications are used judiciously as part of an individualized plan in which the following are carefully considered:

(A) rationale including current DSM diagnosis;

(B) benefits of treatment in light of potential risks of the targeted behavior;

(C) overall impact on the individual's quality of life;

(D) adjunctive procedures;

(E) monitoring of side effects; and

(F) monitoring for efficacy;

(2) when tardive dyskinesia is suspected, the physician:

(A) informs the individual and/or legal guardian;

(B) discusses treatment options; and

(C) documents in the record that the individual and/or legal guardian has been informed of the suspected condition, possible treatment options, and the rationale for the treatment chosen;

(3) the physician obtains a second opinion to review and determine the safety of any usage of polypharmacy or over the maximum dosage levels when clinically indicated prior to the individual receiving such medications;

(4) informed consent in writing for a period not to exceed one year from the individual or legally authorized representative (including a surrogate decision-making committee, if applicable, as described in Chapter 405, Subchapter J of this title (relating to Surrogate Decision-Making for Community-Based ICF/MR and ICF/MR/RC Facilities)) is obtained prior to initiation of the medication unless the use is necessitated by an emergency as described in §408.158 of this title (relating to Behavior Management.). Informed consent must include:

(A) an explanation of the medication and its purposes;

(B) expected beneficial effects, side effects and risks;

(C) probable consequences of not taking medication;

(D) the existence and value of alternative less restrictive forms of treatment, if any, and why the physician rejects the alternative therapy;

(E) instruction that the individual with the ability to provide legally adequate consent or the LAR may withdraw consent at any time without negative actions on the part of staff;

(F) an offer to answer any questions concerning the medication and its use; and

(G) a specification of the time period to be covered by the consent document

(5) informed consent will be obtained on at least an annual basis or any time the medication regimen is altered in a way which would result in a change of medication class or result in a significant change in the risks or benefits to the individual; and

(6) if the individual with the ability to provide legally adequate consent or the LAR consents to the administration of psychoactive medication but is physically unable to provide written consent, the physician will document the verbal consent in the individual's record.

§408.163. References.

Texas laws, department rules, and other standards referenced in this subchapter include:

(1) Texas Health and Safety Code, §531.002;

(2) Texas Health and Safety Code, §534.052;

(3) Texas Health and Safety Code, §534.054(c);

(4) Texas Health and Safety Code, §534.058;

(5) Texas Health and Safety Code, §591.006;

(6) Persons with Mental Retardation Act (Texas Health and Safety Code, Title 7, Subtitle D);

(7) Texas Medical Practice Act;

(8) Chapter 401, Subchapter G of this title (relating to Community Mental Health and Mental Retardation Centers.

(9) Chapter 408, Subchapter C of this title (relating to Quality Assurance and Improvement System (QAIS) for Mental Retardation Services and Supports);

(10) Chapter 405, Subchapter Y of this title (relating to Client Rights – Mental Retardation Services;

(11) Chapter 404, Subchapter B of this title (relating to Abuse, Neglect, and Exploitation of People served by Providers of Local Authorities);

(12) Chapter 408, Subchapter D of this title (relating to Additional Mandatory Standards for Selected Providers of Community-based Mental Retardation Supports and Services); and

(13) Life Safety Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701421
Ann Utley
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Effective date: February 21, 1997
Proposal publication date: September 20, 1996
For further information, please call: (512) 206-4516

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TITLE 28. INSURANCE

Part I. Texas Department of Insurance

Chapter 19. Agent's Licensing

Subchapter P. Fees Charged by Local Recording Agents

28 TAC §19.1501-19.1503

The Commissioner of Insurance adopts amendments to §§19.1501 - 19.1502 and new §19.1503, concerning fees charged by local recording agents to purchasers of insurance policies. Sections 19.1502 and 19.1503 are adopted with changes to the proposed text as published in the August 27, 1996 issue of the *Texas Register* (21 TexReg 8083). Section 19.1501 is adopted without changes and will not be republished.

The amendments to these sections and new sections are necessary to delete reference to repealed Insurance Code, Article 21.14, §4(e) and insert reference to the Insurance Code, Articles 21.35A and 21.35B concerning reimbursement and payments agents are permitted to charge clients. The department has received calls from agents who are confused as to what fees they are allowed to charge insurance customers. The department has also received calls from consumers complaining of being charged fees without their knowledge. These sections will help to ensure that both local recording agents and consumers know what fees may be properly charged and to ensure disclosure of fees to purchasers of insurance. This will discourage agents from charging fees without the consumer's knowledge and enable consumers to make more informed decisions when purchasing insurance.

The amendments to §§19.1501 - 19.1502 and new §19.1503 harmonize the provisions of Articles 21.35A and 21.35B. In response to comments, several changes were made to the subchapter. The definition for agent fee was changed to clarify that agents may charge a fee for services the agent agrees to perform, not just services the agent has actually performed. The definition for fees was deleted as unnecessary since the definition for service fee has also been changed to include language which more closely follows the provisions of the statutes. The definition for policy fee has been amended to show that the charge is in addition to the premium and that it may also be collected by a managing general agent and a surplus lines agent on behalf of an insurer. Existing §19.1503, which refers to adoption by reference of the Disclosure Statement for Local Recording Agents' Fees form, has been repealed elsewhere in

this issue of the Texas Register. New §19.1503, which sets out the procedures which must be followed when local recording agents charge clients fees under Articles 21.35A or 21.35B, has been changed. Generally, local recording agents must disclose to a client, in writing, the following: that the agent has notified the client of the agent's reimbursement or fee requirement; the policy fee, agent fee, service fee or inspection fee, if any, charged by the agent on the transaction; the client's written agreement to the charges (Article 21.35A only); the client's signature; the toll-free telephone number of the department for information on how to file a complaint; an itemized list of the services provided and the corresponding charges for each service. Section 19.1504 has been repealed elsewhere in this issue of the *Texas Register* since the text of that section is now included in new §19.1503.

Comment: Commenters believe that Article 21.35A and Article 21.35B do not authorize promulgation or adoption of the proposed rules by the Commissioner of Insurance. Commenters believe that the language in Article 1.03A which permits the Commissioner to adopt rules and regulations "only as authorized by statute" does not itself authorize the Commissioner to adopt rules and regulations independently of another statute's authorization to adopt rules. The commenters contend that Article 21.35A contains no authority for the promulgation of rules and Article 21.35B has very limited authority for the promulgation of rules. The commenters contend that there is no statutory authorization for the type and scope of rules proposed.

Response: The agency disagrees. Article 1.03A was passed by the 73rd Legislature in 1993. A review of the legislative history of Article 1.03A shows that during debate concerning Article 1.03A on the Senate floor, on May 24, 1993, the sponsor of Article 1.03A agreed that the department must have specific statutory jurisdiction to issue a rule, but each section of the Insurance Code in which the department has jurisdiction need not explicitly reference the department's rulemaking authority. The sponsor of the bill further established that the department only needs general statutory authority to adopt a rule.

Article 1.03A provides the agency with general rulemaking authority to implement, interpret or prescribe law or policy to carry out the provisions of the Insurance Code. Each article of the Insurance Code over which the department has regulatory and enforcement jurisdiction need not explicitly state that "the Commissioner has authority to adopt rules under this article."

Insurance Code, Articles 21.35A, 21.35B, 21.21 and Article 1.03A together provide statutory authority to adopt these rules. The department agrees that Article 1.03A does not itself authorize substantive rules to be adopted by the Commissioner without a specific authorizing statute independent of Article 1.03A. In this case, the specific authorizing statutes independent of Article 1.03A are Articles 21.35A, 21.35B and 21.21.

Article 1.03A authorizes the Commissioner to adopt rules for the conduct and execution of the "duties and functions" of the department only as authorized by statute. Insurance Code, Articles 1.01A and 1.09 establishes the "duties and functions" of the department as the regulation of the business of insurance in this state and implementation of the purpose of the Insurance Code. Articles 21.35A, 21.35B, and 21.21 are the "authorizing statutes" under which the Commissioner may exercise his general rulemaking authority under Article 1.03A. Since Articles 21.35A and 21.35B regulate fees and services charged by agents, including local recording agents, the agency has the authority under 1.03A to adopt rules to implement these statutes. The agency also believes that the Commissioner has authority to adopt these sections under Insurance Code, Article 21.21 (Unfair Competition and Unfair Practices). The agency believes that charging consumers fees without their knowledge is "an unfair or deceptive act or practice in the business of insurance" (See Article 21.21, §3) and that requiring disclosure of fees to be charged encourages fair competition and allows consumers to make informed decisions when purchasing insurance.

Comment: A commenter has a concern about the aggregation of Article 21.35A and Article 21.35B to propose one set of rules since the statutes were enacted at different times and deal with different subjects. Article 21.35A provides for local recording agents' reimbursement for costs incurred in providing services to insurers; Article 21.35B provides for insurers, agents and sponsoring organizations to recover various fees and costs, which may or may not include the costs described in Article 21.35A.

Response: The agency disagrees with the contention that because the statutes were enacted at different times and deal with different subjects that a single rule cannot implement both statutes. Articles 21.35A and 21.35B both address closely related subjects and regulate fees charged not only by local recording agents (21.35A), but other entities (21.35B). The agency believes that it is appropriate to require disclosure of fees which may be charged in a single rule addressing fees. Although Article 21.35B is broader in scope than Article 21.35A because it deals with both permissible reimbursement for fees and permissible payments and applies to agents and entities other than local recording agents, this does not mean that rules cannot address disclosure of fees authorized in both articles. Article 21.35B refers to service fees, including charges for costs described under Article 21.35A. Although Article 21.35A applies specifically to local recording agents, Article 21.35B also includes local recording agents. It is entirely appropriate and reasonable to combine different statutes into one rule to address disclosure of fees, particularly when one of the statutes refers to the other.

Comment: One commenter objects to the changes made to the sections from the published proposal. The commenter argues that the changes are substantive and requests that the sections be republished. The commenter also objects to the elimination of a standard disclosure form, arguing that some consumers may receive clear disclosure while others might receive poor disclosure.

Response: The changes to the sections do not affect a new group of people nor do the changes impose a greater burden on the group of people affected by the sections. Therefore, the agency disagrees that the changes to the sections from the published proposal are substantive; nor does the agency believe that the sections should be republished. The requirement of a standard disclosure form was eliminated from the proposed sections because local recording agents are already required to disclose fees and obtain consumers' written consent to fees collected under Article 21.35A. Requiring that

agents use a standardized form may interfere unnecessarily with local recording agents' ability to adjust the disclosure forms they are currently using to incorporate the requirements of these sections. In requiring disclosure of fees under Article 21.35B, the agency does not seek to add unnecessarily to the costs agents must incur to comply with the sections, but simply to ensure consumers know what fees they are being charged. Requiring disclosure of fees helps to achieve that goal. Finally, there would be additional costs to the state for developing a standard disclosure form which were not anticipated in the sections as proposed. §19.1501

Comment: A commenter suggested applying the sections to all agents.

Response: The agency agrees with the concept of requiring all agents to disclose fees that are charged to an insured but has not made the recommended change in these sections. The agency published these sections requiring disclosure of fees by local recording agents and it would be inappropriate to apply this rule to agents other than local recording agents since other agents have not been put on notice of application of these sections to them. §19.1502 - Definitions

Comment: Several commenters suggested deleting the word "made" after the word "charge" in the various definitions as unnecessary.

Response: The agency agrees and has made the changes.

Comment: One commenter requested clarifying the definition of "agent fee" by including the words "or services" and "agrees to perform" rather than actually performs since some services are performed in the future.

Response: The agency agrees and has made the suggested change since it makes the definition more accurate.

Comment: One commenter believed the words "in lieu of" in the definition for "policy fee" was unclear and believed the words "in addition to" added nothing to the definition.

Response: The agency believes the commenter has confused the definition for "policy fee" with the one for "agent fee" since the words "in lieu of" are not part of the definition for "policy fee". The agency believes, however, that the words "in addition to the premium" in the definition of "policy fee" correctly define the term.

Comment: A commenter suggests that subparagraph (B) in the definition of "fees" is unnecessary as it repeats the wording in the definition of "service fee" and is already included in subparagraph (C) of the "fees" definition. A commenter recommends adding the words "reasonable charge" prior to the listing of the various fees. Another commenter suggests deleting the fee definition.

Response: The agency has deleted the definition of "fees" as unnecessary since it has made other changes to the definitions due to comments received and the definition is no longer necessary.

Comment: Some commenters believe that the definition of "policy fee" is unworkable as it relates to disclosure by the local recording agent of fees charged by county mutual insurance companies, managing general agents (MGAs) and surplus lines agents. The commenters believe that these fees are controlled by parties other than the local recording agent and it is unreasonable to require local recording agents to disclose fees outside their control. The commenters also believe that the local recording agent is unable to comply with the disclosure requirement in proposed §19.1503(c)(4), because the local recording agent does not know what fees are being charged or what services are being provided by the insurer, the MGA or the surplus lines agent. The commenters feel that the local recording agent should not be responsible for disclosing and explaining a fee charged by another entity. Further, the agent may not know the amount of the policy fee before the close of the transaction. The commenters state that some local recording agents know what policy fee is being charged on a policy at the time a transaction is being completed, but many agents will not have that information before the transaction is completed. The commenters assert the disclosure of such fees would be a burden on the vast majority of local recording agents who do not now charge fees on their own behalf and do not intend to charge fees to their customers in the future. Commenters recommended various changes to the definition of "policy fee" to include no requirement of disclosure if the policy fee is reflected on the declaration page of the policy. The commenters further state that "policy fees" are shown on the policy declarations page and are subject to premium tax as a part of the premium, as required by Insurance Code, Articles 1.14-2 and 4.10, and do not need to be disclosed again. Another commenter objects to the elimination of the requirement that policy fees be disclosed only if not listed on the policy declarations page. The commenter asserts that by the time consumers get their declarations page and learns of the policy fee, they have already lost the opportunity to reject the fee.

Response: The agency is not attempting to require local recording agents to disclose something that is outside of their control, rather it wants local recording agents to disclose those fees they charge customers so that customers can make knowledgeable decisions. The agency has changed the definition of "policy fee" to clarify that the policy fee is charged on behalf of the insurer, managing general agent or surplus lines agent. The agency agrees that if the policy fee is disclosed on the policy declaration page, there is no necessity for the fee to be disclosed also on the disclosure form. The agency reasserts that the purpose of the sections is to provide disclosure of fees charged by agents so that consumers can make informed decisions. Since policy fees are not charged by the agent, but by the insurer, requiring disclosure of policy fees only if they are not separately disclosed on the declarations page is reasonable and consistent with the purpose of the sections. As to the commenter who argues that the consumer has lost the opportunity to reject the policy fee by the time he or she receives a copy of the declarations page of the policy, the agency does not believe that requiring the disclosure of policy fees before the close of the transaction will address this issue since the policy fee, as defined in these sections, is charged by the insurer, not by the agent. The proposed sections as published sought to address the problem of agents who charged consumers fees, which were labeled as "policy fees", without the consumer's knowledge. By requiring that policy fees be disclosed if they are not disclosed on the declarations page of

the policy, this problem is addressed since the agent must then disclose any fee that may be improperly labeled a policy fee.

Comment: A commenter suggested deleting the last sentence of the definition of service fee. Under Article 21.35A (c), these charges are not limited to the actual costs incurred by the agent. Another commenter objects to the change in the definitions which no longer defines a reasonable fee as the actual cost. The commenter believes that this change removes consumer protection by providing no guidance on the term "reasonable".

Response: To be consistent with Article 21.35A, the agency has changed the definition of service fee to specify those charges which are to be based on actual costs and those charges for which the fee charged must be reasonable, and to clarify to local recording agents the fees which may be charged. The agency has made the change in the definition for service fee to include the actual cost for those items specified in Article 21.35A(b) and the reasonable cost for those items specified in Article 21.35A(c) because it more closely follows the actual language and requirements of the statute. As previously stated, the purpose of these sections is to provide for disclosure of fees so that consumers may make more informed decisions when buying insurance and to clarify to both local recording agents and consumers what fees agents may properly charge. §19.1503

Comment: Commenters suggested exempting "policy fees" as defined in the proposal from the disclosure requirements. Another commenter was concerned that the sections improperly required the consumer's written agreement to charges under Article 21.35B when written agreement to charges is only required under Article 21.35A. Another commenter suggested separating the procedures to be followed for the fees permitted in Articles 21.35A and 21.35B.

Response: The agency has changed this section, as recommended by one commenter, to differentiate between the fees permitted in Article 21.35A and Article 21.35B and the procedures which must be followed for each article. The section now requires written agreement only for those fees charged under Article 21.35A. The agency disagrees with exempting policy fee from the disclosure requirements in this section. Since the agency has changed the sections to require disclosure of a policy fee only if it is not separately disclosed on the declarations page of the policy or endorsed onto the policy, the agency does not believe it is appropriate to make the recommended change.

Comment: Commenters objected to the lengthy record keeping requirement in §19.1503(d). The commenters stated that agents will keep records of fees in the individual customer file and that any complaint concerning a fee is a complaint from a specific customer. The required disclosure information will be readily available for the agency to inspect or copy the agents' customer files. The commenters further stated that agents retain files for as long as that person remains an active customer, but most agents purge their files three years after the person is no longer an active customer. The commenters feel that three years is an adequate period of time for retention. A commenter expressed concern over the need to maintain the disclosure form in a separate file.

Response: The agency does not believe that retaining records for a period of five years is an unreasonable amount of time. The records must be available when the agency needs to review the records. A five year retention period is consistent with other rules on retention of records (See §19.1204(b)(16) Licensing and Regulation of Managing General Agents). Additionally, Insurance Code, Article 1.41 sets out a five year limitation period for imposing sanctions, penalties or fines against insurers, agents or other licensees subject to the agency's jurisdiction when there has been a violation of the Insurance Code or other insurance laws of the state. Therefore, the agency believes that retention of records for five years is reasonable and necessary to help in its enforcement of Texas insurance laws. The agency understands the concern over separate files and has deleted the requirement of maintaining the disclosure forms in a separate file as unnecessary.

Comment: A commenter suggests that the agency consider repealing 28 TAC §5.20l and incorporating it into this new proposed rule. If not, the agency should clarify §5.201 as an exception to local recording agents.

Response: The agency disagrees with incorporating the suggested repeal into this proposal. Repeal of §5.201 was not included in the notice of this proposal and it would not be within the scope of this proposal to attempt to repeal another rule without putting the public on notice. The agency will consider what, if anything should be done regarding §5.201.

FOR: Texas Association of Insurance Agents, Texas County Mutual Association, Texas Surplus Lines Association.

AGAINST: Automobile Insurance Agents of Texas, Inc., Center for Economic Justice.

The amendments and new sections are adopted under the Insurance Code, Articles 21.35A, 21.35B, 21.21 and 1.03A. The Insurance Code, Article 21.35A sets out the fees a local recording agent may charge a client for reimbursement of certain costs. Article 21.35B establishes the various payments an insurer, its agent, or sponsoring organization may collect. Article 21.21 regulates trade practices in the business of insurance by defining and prohibiting unfair methods of competition or unfair or deceptive acts or practices. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by a statute. The Government Code, §§2001.004 et seq. authorizes and requires each state agency to adopt rules of practice setting forth the nature and requirements of available procedures and to prescribe the procedures for adoption of rules by a state agency.

§19.1502. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

Agent fee - A charge by a local recording agent, in lieu of or in addition to the commission, for services the agent agrees to perform in connection with the sale or service of a particular policy.

Inspection fee - A charge by a local recording agent for examination of a risk to be insured to determine acceptance, rejection or rate.

Local recording agent - A person subject to licensing under Insurance Code, Article 21.14.

Membership dues - A payment or obligation required by an organization or group for an individual to be considered a member or part of the organization or group.

Policy fee - A charge by a local recording agent on behalf of an insurer, managing general agent or surplus lines agent in connection with issuance of the policy. This charge is in addition to the premium.

Service fee - A charge by a local recording agent for actual costs incurred in obtaining a motor vehicle record of a person, or a photograph of property, insured under, or to be insured under, an insurance policy; or the reasonable costs of special delivery or postal charges, printing and reproduction costs, electronic mail costs, telephone transmission costs, and similar costs incurred by the agent on behalf of the client.

§19.1503. Procedures for Charging Fees.

(a) A local recording agent may charge a client a service fee to reimburse the agent for actual costs as specifically enumerated in and in accordance with the Insurance Code, Article 21.35A(b). A local recording agent may also charge a client a reasonable service fee for those items listed in Insurance Code, Article 21.35A(c). A local recording agent may not charge a service fee unless the agent notifies the client of the service fee (including for reimbursement of actual costs) and obtains the client's written consent for each item charged under the service fee prior to the local recording agent incurring an expense on behalf of the client.

(b) Local recording agents may, aside from service fees, charge a client policy fees, agent fees, inspection fees and membership dues in accordance with Insurance Code, Article 21.35B.

(c) The local recording agent must follow the procedures for disclosure set out in this subsection when charging a client for these fees. The local recording agent must obtain the client's signature on a disclosure form. The local recording agent must disclose, to a client, the following information in the written disclosure form signed by the client:

(1) that the agent has notified the client of the agent's reimbursement or fee requirement prior to incurring the expense or providing the service;

(2) the agent fee, service fee or inspection fee, if any, charged by the agent on the transaction. If a policy fee is charged which is not separately disclosed on the declarations page of the policy or endorsed onto the policy, the agent must disclose the policy fee;

(3) the toll-free telephone number (1-800-252-3439) of the Texas Department of Insurance and a statement in bold face type advising the client that the client may call that number to obtain information on how to file a complaint if the client has a complaint regarding such fees; and

(4) a complete, itemized listing of the fees being charged and, if a service fee is charged, a complete itemized listing of the services provided and the corresponding charge for each item under the service fee.

(d) All files relating to fees, including written records of disclosure of fees, must be maintained for a period of five years and must be made available to the Texas Department of Insurance for inspection or copying upon request to insure compliance with this subchapter and Texas Insurance Code, Articles 21.35A and 21.35B.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-971475
Caroline Scott
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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28 TAC §§19.1503 - 19.1504

The Commissioner of Insurance adopts the repeal of §§19.1503-19.1504 concerning fees charged by local recording agents to purchasers of insurance policies. The repeal of these sections is adopted without changes to the proposed text published in the August 27, 1996 issue of the *Texas Register* (21 TexReg 8085).

Section 19.1503 is repealed because the department will no longer promulgate a form for disclosure of fees charged by local recording agents. The repeal of §19.504 is necessary to delete reference to repealed Insurance Code, Article 21.14, §4(e) and enable adoption of new §19.1503 to insert reference to Insurance Code, Articles 21.35A and 21.35B concerning reimbursement and payments agents are permitted to charge clients.

The repeal of these sections eliminates a procedure no longer used by the department, deletes reference to a repealed statute, and enables the Commissioner of Insurance to adopt new §19.1503 concerning fees charged by local recording agents, which appears elsewhere in this issue of the Texas Register.

No comments were received on the proposal as published in the *Texas Register*.

The repeals are adopted pursuant to the Insurance Code, Articles 21.35A, 21.35B, and 1.03A. The Insurance Code, Article 21.35A sets out the fees a local recording agent may charge a client for reimbursement of certain costs. Article 21.35B establishes various payments an insurer, its agent, or sponsoring organization may collect. Insurance Code, Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by a statute. The Government Code, §§2001.004 et seq. (Administrative Procedure Act) authorize and require each state agency to adopt rules of practice setting forth the nature and requirements of available procedures and to prescribe the procedures for adoption of rules by a state agency.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Caroline Scott

General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

Part XX. Edwards Aquifer Authority

Chapter 721. Interim Critical Period Management Rules

The Edwards Aquifer Authority (Authority) adopts new subchapters A through H, §§721.1-721.8, 721.11-721.12, 721.21-721.24, 721.31-721.33, 721.41-721.48, 721.51, 721.52, 721.61-721.65, 721.71 and 721.72, concerning interim critical period management rules,. Proposed §§721.5, 721.12, 721.21–721.24, 721.31–721.33, 721.41–721.45, 721.47, 721.48, 721.51, 721.52 and 721.61 are adopted with changes to the proposed text as published in the September 3, 1996, *Texas Register* (21 TexReg 8405). Proposed §721.34 has been withdrawn, but the substance of its text has been incorporated with changes into 721.5(a)(6). Sections 721.1–721.4, 721.6–721.8, 721.11, 721.46, 721.62–721.65, 721.71, and 721.72 have been adopted without changes.

The Authority adopts these new rules pursuant to the Conservation Amendment of the Texas Constitution, article 16, section 59; the powers and duties of the Authority to promulgate and enforce rules to implement a critical period management plan under the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended (the "Act"), §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41; and chapter 36 of the Texas Water Code.

The purpose of these critical period management rules is to reduce withdrawals from the Edwards Aquifer in order to protect and preserve available water supplies during critical periods in accordance with the Authority's Critical Period Management Plan, which was published for public comment along with the proposed rules, 21 TexReg 8406 (September 3, 1996). The rules are intended to be in force and effective for an interim period. The Authority intends to replace these interim rules with permanent critical period management rules after the permitting system and the comprehensive management plan required by the Act have been implemented.

The rules are designed to accomplish the following goals: to protect public health, safety and welfare; to sustain springflow levels at Comal and San Marcos Springs and protect endangered species and their habitats; to provide downstream water flows; to prolong and promote water supplies throughout the region; to protect water quality; to minimize economic losses; to delay or avoid the day when substantial reductions will have to be made of essential uses of underground water; and to preserve state sovereignty and regional control of the aquifer.

The critical period management rules as adopted differ in some respects from the rules as proposed. Revisions to the proposed rules were made as a result of comments received from the public and further review by staff. Specific changes and reasoned justification for the changes and agency responses to comments are addressed below. The numbering of the adopted rules is the same as the proposed rules with one exception. Section 721.34 has been withdrawn, but the text of proposed §721.34 now appears as part of the definition of "base usage" at §721.5(a)(6). In addition, subsection designations have changed in several of the rules, including the definitions section §721.5, the section describing the critical period stages (§721.24), and the section dealing with monthly use reports (§721.52), to reflect additions or deletions to those sections.

Subchapter A of the rules, relating to general provisions, contains §§721.1-721.8. Those rules provide a general statement of the purpose, authority, and the circumstances that make the rules necessary, set forth definitions and abbreviations of words and terms when used in the chapter, set forth the computation of time for filing documents with the Authority, require a person subject to the rules to notify the Authority of a change of address within fourteen days, and provide for severability. Section 721.2 provides that the rules apply throughout the jurisdictional boundaries of the Authority. Section 721.5 is the definitions section. The definitions of "aquifer" and "underground water" make clear that the rules apply only to water within or produced, obtained, or originating from the Edwards Aquifer. "Underground water" does not include recycled, reclaimed or reused water.

"Essential uses" are defined as those uses of underground water which are not defined as discretionary uses and which are essential to the protection of public health, safety, or welfare, essential to industrial use or agricultural or military activity which directly supports gainful employment, or essential to irrigation use. "Discretionary uses" are expressly defined to include recreational use to the extent the underground water is not recycled (including the watering of turf areas), landscape watering (including residential, commercial and public landscapes, golf courses, athletic fields, and cemeteries), filling or maintaining swimming pools, operating outdoor fountains, washing of parking lots and other impervious outdoor ground coverings, and use in an aquaculture operation to the extent the water is not recycled. The term "landscape watering" means the application of underground water to grow or maintain plants, but does not include production use by a nursery, watering of a family garden or orchard, or limited application to a concrete foundation to prevent damage. Notwithstanding these definitions, any use of underground water that is necessary to prevent danger to public health, safety, or welfare or that is required to comply with state or federal law, is considered essential.

Subchapter B, relating to applicability of the rules, explains which persons are "primary users" subject to the rules and which uses are exempt from the rules. A "primary user" is any person who withdraws or supplies more than 25,000 gallons per day of underground water, see §§721.11, 721.5(a)(28). A primary user who supplies more than 25,000 gallons of underground water per day is termed a "primary supplier," §721.5(a)(27). "Withdraw" is defined broadly to mean to "effect, cause, suffer, allow or permit" taking of water from the Edwards Aquifer through either action or inaction, §721.5(a)(40), (41). Thus, any person who owns, leases, or has actual or constructive possession of a producing Edwards Aquifer well or

the land upon which the well is located "withdraws" from that well. All primary users, except irrigation users, are subject to the maximum allowable usage limits mandated by subchapter D of the rules, §§721.31-721.33, and must file base usage reports and monthly usage reports during critical period stages in accordance with subchapter F, §§721.51-721.52.

Section 721.12 provides that no person is required to reduce withdrawals of underground water from any well that produces 25,000 gallons per day or less, under either the maximum allowable usage limitations or specific water use restrictions of these rules. Exempt users are encouraged to comply with the landscape watering restrictions. Section 721.12(b) states that no person is required to reduce the amount of underground water withdrawn or supplied to the extent it is used for an essential use as defined in §721.5(a)(14). Certain uses are expressly defined as discretionary, §721.5(a)(12), and thus are excluded from the definition of essential use. Persons subject to mandatory reductions or specific restrictions must reduce discretionary uses to the maximum extent feasible as may be necessary to comply. All persons are subject to §1.35(c) of the Act, which prohibits the waste of underground water, regardless of the amount of water produced or the use of the water.

Subchapter C, relating to critical period stages, divides the Authority into three compliance areas for purposes of the critical period stages established in these rules. As stated in §721.21, the eastern area consists of Bexar County and portions of the counties of Comal, Hays, Caldwell, and Guadalupe within the Authority. Stages in the eastern area are triggered by aquifer levels as measured at Well J-17 in San Antonio. Stage I is triggered when the J17 level falls to 650 feet above mean sea level ("ft. m.s.l."). Stage II is triggered when the J-17 level falls to 642 ft. m.s.l. Stage III is triggered when the J-17 level falls to 636 ft. m.s.l. Stage IV is triggered when the J-17 level falls to 632 ft. m.s.l.

As stated in §721.22, the Medina area consists of Medina County and the portion of Atascosa County within the Authority. Stages in the Medina area are triggered by the aquifer level as measured at the Hondo Yard Well in Hondo. The stages in the Medina area are as follows: Stage I - 670 ft. m.s.l.; Stage II - 660 ft. m.s.l.; Stage III - 655 ft. m.s.l. Section 721.23 states that the Uvalde area consists of Uvalde County. Stages in the Uvalde area are triggered by the aquifer level as measured at Well J-27 in Uvalde. The stages in the Uvalde area are as follows: Stage I - 845 ft. m.s.l.; Stage II - 840 ft. m.s.l. The rules do not provide for Stage IV to be triggered in the Medina area, or for Stages III or IV to be triggered in the Uvalde area.

The critical period stages in these three compliance areas, along with the applicable reduction multipliers, are stated at §721.24(d) and (e), Figure 1. A reduction multiplier is used to calculate a primary user's maximum allowable usage. The reduction multipliers are as follows: Stage I - 1.8 x base usage; Stage II - 1.6 x base usage; Stage III - 1.4 x base usage; Stage IV - either 1.2, 1.3, or 1.4 x base usage. As stated in 721.24(d), if the Authority determines to implement its voluntary Irrigation Suspension Program for 1997, the reduction multiplier for participants in the program will be 1.4. If the program is not implemented, the board will, by order issued no later than April 10, 1997, establish the applicable reduction multiplier in Stage IV, in which case the multiplier will not exceed 1.4 nor be less than 1.2.

Section 721.24(a) provides that the general manager of the Authority is required to make daily postings of springflow rates and well levels, the 10-day rolling average of these values, and the stage which is in effect in each of the three compliance areas. Section 721.24(c) states that once a stage is triggered in a compliance area, it will remain in effect for at least ten days, and will not be rescinded until the 10-day average of the aquifer level is above the applicable trigger point.

Subchapter D of the rules, relating to maximum allowable usage and enforcement, creates maximum allowable usage limits for use of underground water by primary users as well as enforcement of the rules. Section 721.31 states that maximum allowable usage is computed by multiplying a user's base usage by the reduction multiplier applicable to the critical period stage then in effect. The key term "base usage" is defined in §721.5(a)(6). Generally, base usage is the average of a user's three lowest monthly water usage volumes for the following four months: November 1995, December 1995, January 1996, and February 1996.

A different base usage formula is provided for conjunctive users. A "conjunctive user" is defined in §721.5(a)(9) as a primary user that uses or supplies water other than underground water in an amount equal to at least 10% of the total water used or supplied in the preceding 12 months, if the non-Edwards Aquifer water relieves demand on the Edwards Aquifer, all available non-Edwards Aquifer water is used or supplied first, and the first qualifying use of non-Edwards Aquifer water occurred after 1986. If a primary user qualifies as a conjunctive user, §721.5(a)(6) provides that the user's base usage is computed as the average of the three lowest months among the four months of November, December, January, and February, for the three 12 month periods preceding the first qualifying use of nonEdwards Aquifer water.

Section 721.32(a) states that a primary user other than an irrigation user is prohibited from withdrawing or supplying more than its maximum allowable usage during any critical period stage, but makes clear that this prohibition does not apply to exempt withdrawals or essential uses under §721.12. This prohibition will be enforced beginning on the effective date of the rules, which is the 20th day following the date the adopted rules were filed with the Secretary of State.

Section 721.32(c) provides an adjusted formula for maximum allowable usage to be used in an action brought by the Authority to enforce maximum allowable usage limits against certain primary suppliers who experience unavoidable drought-caused water main breaks. In such an enforcement action, a primary supplier that has exceeded its maximum allowable usage limit as computed on total withdrawals is entitled to a calculation of maximum allowable usage based on total metered sales rather than total amount of water withdrawn if the supplier proves that the exceedance is due to nonpreventable water main breaks caused by dry weather conditions during the critical period, the unaccounted-for water is less than 20% of total water pumped by the supplier or does not exceed 25 million gallons per day, whichever is lower, the supplier implements and maintains an aggressive leak detection program, and the supplier exercises

reasonable diligence in detecting, repairing, and preventing the breaks. If the supplier successfully establishes that the metered sales formula should be applied in accordance with this section, the supplier will not be subject to fines or penalties for the exceedance to the extent the exceedance is proven by the supplier to have been caused by the nonpreventable water main breaks.

Section 721.33 makes it the general manager's duty to calculate base usage and maximum allowable usage for every primary user, other than an irrigation user, based on the base usage report and other available information. In particular cases, the general manager has discretion, with approval from the board, to calculate base or maximum allowable usage on different criteria more appropriate for a particular primary user in order to approximate better the minimum amount of water needed by that primary user for essential uses, or to avoid penalizing a user for development of alternative water supplies. Primary users have the duty to calculate their own base and maximum allowable usage values for purposes of compliance. If a primary user disagrees with the general manager over the determination of base or maximum allowable usage, the user is entitled to seek review by the general manager and the board in accordance with §721.71 and §721.72.

Section 721.32(d) provides for enforcement of the rules. Any person that violates any term or provision of any subchapter of the rules may be assessed an administrative penalty or subject to a suit for injunction or civil penalties in state district court. The procedure by which the Authority can assess an administrative fine is detailed in the Act, §1.37. The fine may be in an amount of not less than $100 per day nor more than $1,000 per day per violation. Section 1.40 of the Act states that the Authority may seek a civil penalty in court against any person who violates the Act or a rule of the Authority. The court-imposed fine may be in an amount of not less than $100 per day or more than $10,000 per day per violation. Section 1.40 states that the Texas Natural Resource Conservation Commission can also seek civil penalties for violations of the Act or of any rule, permit, or order adopted or issued by the Authority under the Act.

Subchapter E, relating to restrictions on specific uses, creates specific restrictions on particular uses of underground water, depending on the critical period stage in effect. Unlike the maximum allowable usage limits, which apply only to primary users, these specific restrictions apply to all persons within the jurisdiction of the Authority. Section 721.41 states that primary users must achieve the maximum allowable usage level at each critical period stage by conserving underground water, minimizing waste, and reducing discretionary uses to the maximum extent feasible. The section again makes clear that essential uses of water as defined in §721.5(a)(14) are not subject to mandatory reductions. The section also requires primary suppliers to make timely and effective use of inverted rate structures, conservation charges, critical period surcharges, and other programs to reduce discretionary demand for water during critical periods. This latter provision implements the requirement in §1.26(3) of the Act.

Section 721.42 provides for specific restrictions applicable in Critical Period Stage I and subsequent stages, except to the extent the restrictions are more restrictive for subsequent stages. When Stage I is in effect and continuing as long as any stage is in effect, no person is allowed to waste underground water and no person is allowed to use underground water for landscape watering between the hours of 10:00 a.m. and 8:00 p.m., for washing of impervious outdoor ground coverings, or for residential car washing except on designated watering days. Restaurants must not serve underground water unless requested. Swimming pools are required to be covered by a cover, screen or evaporation shields covering at least 25% of the surface of the pool when not in active use. No person is allowed to permit irrigation tailwater to escape from the property. Charity car washes are prohibited unless held at a car wash that recycles at least 75% of the underground water it uses or is certified as a conservation car wash.

Section 721.43 provides for specific restrictions applicable in Critical Period Stage II. When Stage II is in effect, landscape watering is limited to two watering days per week, except that watering by means of a bucket (not to exceed 5 gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system is permissible on any day before 10:00 a.m. and after 8:00 p.m. Municipalities must set their own watering days so as to reduce peaks of demand. The watering days for areas outside of municipalities are Saturday and Wednesday. Outdoor fountains are prohibited unless they recirculate water.

Section 721.44 provides for specific restrictions applicable in Critical Period Stage III. When Stage III is in effect, landscape watering is limited to one watering day per week, except that watering of ornamental plants other than grass or turf by means of a bucket (not to exceed 5 gallons in capacity), hand-held or soaker hose, or properly installed drip irrigation system is permissible on any day before 10:00 a.m. and after 8:00 p.m. Municipalities must set their own watering days so as to reduce peaks of demand. The watering day for areas outside of municipalities is Saturday. Outdoor fountains are prohibited altogether.

Section 721.45 provides for specific restrictions applicable in Critical Period Stage IV. When Critical Period Stage IV is in effect, landscape watering is limited to one day in any calendar week restricted to the morning hours of 3:00 a.m. to 7:00 a.m. and the evening hours of 8:00 p.m. to 11:00 p.m. The watering of ornamental plants other than grass or turf by means of a bucket (not to exceed five gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system is allowed any day of the week during the morning hours 7:00 a.m. to 11:00 a.m. Persons using irrigation systems requiring more than seven hours to complete one weekly watering cycle may seek a variance accompanied by a water conservation and reuse plan. Outdoor fountains continue to be prohibited. Filling of all new and existing swimming pools is prohibited unless at least 30% of the water is obtained from a non-Edwards Aquifer source. However, underground water can be used to replenish pools to maintain appropriate pool levels. Drainage of pools, when necessary, is allowed only onto a pervious surface or pool deck where the water is transmitted directly to a pervious surface.

Sections 721.47 and 721.48 treat golf courses and athletic fields separately from other types of landscape watering. Section 721.47, relating to golf courses, sets out two categories of golf courses: conforming and non conforming. A conforming course is one that timely files an adequate water use reduction plan with

the Authority which provides for conversion to an alternative water supply, if feasible, and usage of a computer controlled irrigation system. Such a plan must be filed within 30 days of the effective date of these rules, and will be approved or disapproved by the general manager within 30 days unless the general manager requests additional information. If the golf course is conforming, it must achieve the following reductions in the replacement of daily evapotranspiration rates or daily soil holding capacity: Stage I: 10%; Stage II: 20%; Stages III & IV: 30% (20% if the conforming golf course is a participant in the Irrigation Suspension Program). If the golf course is non-conforming, it must achieve the following reductions in replacement of daily evapotranspiration rate (or the correlative reduction multiplier for courses that do not have a computer controlled irrigation system): Stage I: 10% (1.8 x base usage); Stage II: 20% (1.6 x base usage); Stage III: 30% (1.4 x base usage); and Stage IV: 40% (1.3 x base usage).

Section 721.48, relating to athletic fields, allows an owner or operator of an athletic field to file a conservation and reuse plan within 30 days after the effective date of the rules. The general manager will approve or disapprove the plan or request additional information within 30 days of filing. In addition to identifying information, the plan must describe the water delivery system used and when it is used, describe the watering practices used to control the amount of water applied, identify any turf areas that are not essential to the functioning of the field, and state what the owner or operator believes is a minimum watering regimen during critical periods that applies only the amount of water necessary to maintain the viability of the turf without creating a safety hazard. The plan must also state what actions the owner will take to obtain alternative water supplies, include a copy of any letter of commitment from a water purveyor regarding alternative water supplies, and state that the plan complies with local conservation plans.

Subchapter F, relating to reports, requires primary users other than irrigation users to file two kinds of reports. Under §721.51, base usage reports must be filed within 30 days of the effective date of the rules. This one-time report must provide information about the user such as name, address, location of wells, amount of water withdrawn or supplied within the past 12 months, estimated amount of water applied to essential uses, and a summary of the user's efforts to conserve water. The information provided in this report will be used by the general manager to calculate the user's base usage and maximum allowable usage. Section 721.52 requires primary users to file monthly usage reports for any month in which a stage was in effect. These reports must provide information concerning the amount of water withdrawn or supplied during the reporting month, the estimated amount of water applied to essential uses during the reporting month, and any other information requested by the general manager. These monthly reports must be filed with the Authority no later than the 5th business day of the month following the reporting month, except in special cases where the general manager in advance approves a different reporting regimen. If a primary user without good cause fails to file timely the monthly use report, the user is prohibited from excluding exempt or essential uses of water from mandatory reductions for the reporting month.

Subchapter G, relating to variances, establishes a procedure for persons to request variances from requirements of the rules. Under §721.61, a person may file a written request for a variance stating the facts upon which the request is based, with a certificate that the facts as stated are true and within the person's personal knowledge. Section 721.62 states that the board may grant a variance if it finds that the variance is necessary to avoid an unusual, direct, and substantial hardship or to prevent the evisceration of a vested property right, that there is no other available means of avoiding the hardship or evisceration, that the variance would be consistent with the goals of the Act and the rules, and that it would not harm other users. Variances are subject to such terms and conditions as the board deems appropriate, §721.63, and may be rescinded by the board due to changed circumstances, new information, or non-compliance by the user, §721.64.

Subchapter H, relating to review and reconsideration, provides for internal review of decisions by the general manager and review of board decisions. Under §721.71, any person who wishes to dispute a determination made by the general manager may file a written request for review with the general manager within 15 days of the determination. The general manager may consider additional information submitted by the person and change the determination accordingly. A person who is not satisfied by the general manager's action on the request for review may appeal to the board by filing a written motion for reconsideration within 20 days of mailing of notice of the action, in accordance with §721.72. The board will consider the motion within 30 days, and may make a final decision, delegate the matter to a committee for recommendation to the board, or remand the matter for a contested case hearing before an administrative law judge from the State Office of Administrative Hearings. A final decision of the Authority must contain findings of fact and conclusions of law in accordance with the Administrative Procedures Act, and is subject to judicial review under that act.

Summary of Comments and Agency Responses.

The following entities and persons submitted comments on the proposed rules: Bexar County Water Control and Improvement District No. 10, Canyon Regional Water Authority, Guadalupe-Blanco River Authority, City of Leon Valley, New Braunfels Utilities, San Antonio Water System, City of San Marcos, City of Sequin, St. Mary's University, Gary Pools, United Services Automobile Association, Southwest Research Institute, Vulcan Materials Company, Hyatt Regency Hill Country Resort, San Antonio Golf Association, Friesenhahn Farms, Texas Association of Nurserymen, San Antonio Apartment Association, San Antonio Zoo, Southwest Car Wash Association, Southwest Cattle Raisers' Association, Rep. John Shields, Fay Sinkin, George Rice, Thomas S. Thelen, Tom Culbertson, J.W. Scanlon, John C. Navarro, Hans R.F. Helland. Most of the commenters favored revision and adoption of the rules in some form.

General Comments.

Rules Should Be Interim in Nature. One commenter noted that these rules were drafted in the midst of a critical period without the benefit of a comprehensive management plan or a 20-year plan for alternative supplies, and recommended that the rules be placed into effect on an interim basis pending development

of these other plans. The commenter recommended that the Authority develop a more complete plan before the next stress period with assistance from a working group which includes irrigators, affected industries, utilities and representatives of regional interests. The commenter stated that the rules as ultimately developed should apply water use restrictions and demand management measures to all users of aquifer water. Another commenter stated that the rules are not appropriately named.

Response. The commenter is correct that the Authority's critical period management rules will eventually be integrated with the comprehensive management plan that the Authority is required to develop and implement by the Act. To make it clear that this set of critical period management rules is intended to be interim in nature, the word "interim" has been inserted in the title of the rules. The Authority's Critical Period Management Committee, along with the Board and staff, will continue to work toward a more complete set of rules that is integrated with the Authority's overall water management plan and that addresses all categories of use. Just as occurred during the development of these interim rules, representatives of various user groups will be involved in and contribute to that effort. With respect to the name of the rules, 1.26 requires the Authority to develop and implement a critical period management plan. The name "critical period management rules" is therefore appropriate.

The Rules Should Be Integrated With A Dry-Year Option Plan. Several commenters stated that the Authority's critical period management rules should be integrated with demand management programs such as the "dry-year option."

Response. The dry-year option is a voluntary demand management program wherein payments are made to irrigators or other users to suspend water-consumptive activity for a stated period of time. The program does not involve the lease or transfers of water rights. The Authority's Critical Period Management Plan, 21 TexReg 8406-8407 (Sept. 3, 1996), called for the development of such a dry year option program in connection with the Critical Period Management Plan. In coordination with the Plan, a voluntary pilot program for suspending irrigation use, called the Irrigation Suspension Program, has been developed and is currently being implemented by the Authority for calendar year 1997. The rules have been modified to provide adjusted reduction multipliers for entities that pay funds into the program. See §§721.24(d) and 721.47(b). If the Program is canceled, the reduction multiplier for Stage IV will be determined by the board by subsequent order, §721.24(d). For further discussion of reduction multipliers, see the comments and agency responses relating to §721.24.

Definition of critical period. One commenter stated that the rules should define the term "critical period," and suggested that a critical period should be considered to begin when the aquifer falls below historical average levels. The commenter also stated that the rules as drafted will apply for major portions of the year, thus confusing users as to when the water supply situation becomes truly critical.

Response: Because these critical period management rules set out specific water supply stages for purposes of water use limitations, there is no need to have a separate definition of the phrase "critical period" at this time. In adopting these rules, the Board has determined that when conditions as specified in the rules exist, critical period management justifies the implementation of restrictions under §1.26 of the Act. The Act contemplates that determination of whether and when to exercise critical period management powers is at the discretion of the Authority.

Incentives. One commenter stated that the rules should provide incentives to users for reductions in water use beyond those required by the rules. Another commenter suggested incentives for municipal purveyors who have engaged in effective conservation efforts in the form of an adjustment based on per capita use.

Response. With respect to reductions beyond those required by these rules, it is unclear from the comment what kind of incentive is recommended. The staff invites commenters to submit specific proposals for consideration in the development of future rules. With respect to per capita adjustment of maximum allowable usage for municipal purveyors, the staff agrees that such an adjustment may be appropriate under certain circumstances. These rules give the general manager discretion to use alternative criteria for calculating maximum allowable usage with board approval, §721.33(b), allow for review of decisions of the general manager, §§721.71-721.72, and provide for variances from rule requirements, §§721.61-721.62. These sections provide sufficient avenues for relief for users who believe that they are unfairly penalized by the rules for having implemented effective conservation measures or for suppliers who believe that their per capita consumption rate should be taken into account in calculating their maximum allowable usage.

Rules Will Not Ensure Springflow. One commenter objected to adoption of the rules on the ground that they will not guarantee that the springs will not go dry. The commenter also opined that there is no necessity for critical period management rules at this time because a critical period does not presently exist, and that critical period rules should be triggered only when there is a genuine threat to human health and safety, rather than by falling aquifer levels or springflow rates. The commenter also urged the Authority to have computer model runs performed on these rules to determine their efficacy.

Response. These rules will reduce demand on the Edwards Aquifer during times of insufficient water supply. The rules cannot ensure that the springs will never go dry, as has been shown by computer model runs, but they can mitigate the harmful effects of drought by stabilizing the water levels and artesian pressure in the aquifer during critical periods and making it less likely that the springs will go dry. Aquifer level and springflow rates are well below normal. If the current dry period continues in 1997, aquifer levels could fall to record lows. The staff does not believe that the phrase "critical period" means that the Authority must wait to take action to manage demand on the aquifer until water supply conditions threaten human health and safety. The staff believes that the critical period stage triggers in the adopted rules are appropriate guideposts which allow the region to phase in water use restrictions as drought conditions become more severe. It is necessary to effective critical period management to anticipate the onset or worsening of drought conditions and take meaningful steps to lessen the severity and impact of those conditions on users. As it has in the past,

the Authority will continue to use computer model runs to help develop and refine its critical period management regulations.

Rules Will Not Adequately Protect Downstream Interests. A commenter complained that the rules do not place sufficient restrictions on pumping to protect springflow and the habitats of endangered and threatened species at Comal and San Marcos Springs. The commenter stated that the rules do not go far enough in restricting specific uses of water, and err in dividing the region into three different areas for purposes of critical period stages. Because of these alleged deficiencies, the commenter asserted, the rules place the burden of conservation entirely on the Cities of New Braunfels and San Marcos and other users in the Guadalupe River basin.

Response. The proposed rules require meaningful water use reductions throughout the region. The same specific restrictions that apply to San Marcos apply to San Antonio. According to the Texas Water Development Board's Edwards Aquifer model, no plan can guarantee protection of the endangered specie's habitats under all conditions. The staff believes that the rules fairly spread the burdens of these restrictions throughout the region. The specific restrictions provided in subchapter E of the rules, §§721.41-721.48, incorporate recommendations made during many public meetings. They reflect a sound effort to curtail water use without causing negative economic impacts that are worse than those caused by the drought itself.

Substitute Plans. One commenter stated that the rules should allow a user to submit and use water in accordance with a substitute plan approved by the Authority as long as the applicable reduction requirements are met.

Response. Individualized, substitute plans may be attractive to the individual user, but generally allowing users to opt out of restrictions would be difficult for the Authority to administer and enforce. Specific plans are encouraged, however, for particular kinds of uses; for example, the rules provide for submission of conservation and reuse plans by operators of golf courses and athletic fields.

Areas Outside Municipal Areas. One commenter stated that primary users should not be held responsible for water usage beyond their control, such as usage in areas within the service area of a municipal purveyor outside the territorial limits of the municipality and thus beyond the reach of ordinances.

Response. Municipal purveyors who serve areas outside municipal boundaries must achieve the maximum allowable usage just as rural purveyors whose entire service area is beyond the reach of municipal ordinances.

Eliminating Discretionary Uses. One commenter complained that these rules allow underground water to be applied to discretionary uses when the springflow at Comal Springs falls below the "take" level of 200 cubic feet per second, and that discretionary uses are even allowed in Critical Period Stage IV, the most restrictive of the critical period stages established in the rules. The commenter urged the Authority to ban all discretionary uses throughout the region during Stages III and IV, and to allow discretionary use only with respect to water obtained from alternative supplies. The commenter also urged the Authority to ban irrigation prewatering as a discretionary and wasteful use of water, and to ban use of underground water for new lawns, parks, parkways, golf courses and other landscaped areas, for the protection of new foundations, and for filling or maintenance of new pools.

Response. The rules generally make all discretionary water use subject to curtailment to the maximum extent feasible, to the extent necessary to meet the maximum allowable usage levels mandated by the rules. §721.41(a), (c). The rules also restrict a number of specific uses of water, §§721.41-721.45, depending on the applicable critical period stage. In the judgment of the staff, the rules provide a reasonable approach to limiting discretionary uses during critical periods. An outright ban on all discretionary uses is unnecessary in light of the framework set up by these rules, and would require an unreasonable level of monitoring and enforcement by the Authority. Further, such a ban would have a harsh effect on economically and socially important industries and activities which are dependent on traditionally discretionary uses, such as swimming pools, golf courses, and athletic fields. With respect to irrigation pre watering, the staff does not agree it should be considered a per se wasteful and discretionary use. Pre-watering appears to be an accepted technique to prepare soil for planting, at least with respect to some crops under some conditions. With respect to banning use of underground water for new lawns, parks, parkways, golf courses and other landscaped areas, and for the protection of new foundations or filling or maintenance of new pools, each of these measures was considered and rejected in the process of developing these rules. These rules attempt to strike a balance between water frugality during critical periods and the avoidance of undue or irreparable harm to the economy of the region. The staff does not believe at the present time that effective critical period management requires imposition of a regional no-growth policy. Such a policy would be counterproductive, because it could cripple regional economies and thus make investment in water resource development much less likely.

Automatic Equipment. One commenter stated that the Authority should utilize automatic technical equipment to stabilize springflow at Comal Springs. Another commenter stated that the rules should describe and implement a springflow augmentation program.

Response. Use of springflow stabilization equipment and implementation of a springflow augmentation program are beyond the scope of these interim rules. These possible aquifer management approaches will be considered by the Authority in developing a comprehensive aquifer management plan.

Restrictions Not Sufficient. One commenter expressed the view that the specific water use reduction measures provided in the rules may not be sufficient to meet the reduction goals in Stages III and IV.

Response. The rules require primary users to eliminate discretionary uses of Edwards Aquifer water, to the greatest extent feasible, to the extent necessary to meet the user's maximum allowable usage limit. §721.41. Thus, reductions in discretionary uses beyond those afforded by compliance with the specific reduction measures specified in subchapter E may be necessary.

Use of the Media. A commenter urged the Authority to make use of the media to notify the public concerning critical period stages.

Response. The rules require the general manager to post by 10 a.m. every business day the latest well levels and 10 day rolling averages of those levels and the applicable critical period stage. §721.24(a). The Authority will, to the greatest practicable extent, utilize the media to disseminate information about well levels and stages.

Regulation in Uvalde County. One commenter queried why the rules impose restrictions in Uvalde County when it has not been established, according to the commenter, that pumping in Uvalde County has any impact on springflow.

Response. Because of both Uvalde County's distance from the springs and the hydrologic restriction known as the Knippa Gap, the effect of pumping in Uvalde County on springflow is more attenuated than pumping east of the Knippa Gap. It is therefore reasonable that Uvalde County is subject only to critical period stages I and II, whereas Medina County is subject to stages I-III and the eastern counties are subject to stages I-IV. Although it is not known exactly how pumping reductions in Uvalde County will affect springflow, the staff believes that it is reasonable to expect some significant benefit, especially with respect to artesian pressure within the aquifer.

Effective Date of Act. One commenter objected to the rules on the basis that the actual effective date of the Act creating the Authority is August 31, 1996, and not June 28, 1996, the date of the Texas Supreme Court decision that dissolved the trial court injunction that had prevented the legislation from becoming effective.

Response. The effective date of the Act was June 28, 1996, the date the trial court injunction suspending the effectiveness of the Act was dissolved by the Texas Supreme Court. In any event, this comment, even if correct, is not germane to the enforceability or propriety of these critical period management rules.

Conflict With Interim Authorization. One commenter opined that implementation of maximum allowable usage restrictions on primary users under these rules conflicts with §1.17 of the Act, which grants interim authorization to withdraw underground water to persons who own a producing well as of the effective date of the Act.

Response. The staff does not agree. Interim authorization is expressly subject to the rules of the Authority (§1.17(c)), and in no way precludes the development, adoption and enforcement of critical period management rules under §1.26 of the Act. In fact, §1.26 makes development of a critical period management plan mandatory, without reference to the status of the permitting process. Further, it is clear from the sections of the Act relating to permitting that permitted withdrawals are also subject to critical period management.

Protect Quality of Life. One commenter stressed that the rules ought to be designed to protect the way of life of the community, especially for the poor, and expressed the need to address the water problems through a systematic and scientific approach devoid of political rhetoric.

Response. The staff agrees that preservation of quality of human life in this region is an important value, and has tried to develop these rules accordingly. The staff also agrees that scientific and technical considerations are of great importance in developing aquifer management measures.

Real Property Rights Preservation Act. One commenter asserted that the rules do not meet the requirements of the Texas Private Real Property Rights Preservation Act, Tex. Government Code chapter 2007.

Response. As stated in the preamble published with the proposed rules, 21 TexReg 8410 (Sept. 3, 1996), the Authority has prepared a takings impact analysis of the rules and has determined that the rules would not effect a constitutional or statutory taking.

Comments Referring to Specific Sections.

Section 721.3 Findings. A commenter challenged several of the findings stated in this section. According to the commenter, it is inaccurate to state that the aquifer, wells, or springs will be contaminated by movement of bad water, that federal authorities can or will exercise control over the aquifer, and that there is a threat to public health and safety. The commenter also stated that pumping restrictions are not the only management option available to the Authority, and that protection of endangered species should not be a primary concern of the Authority.

Response. The staff supports the findings stated in §721.3. Some experts believe that there is a risk of intrusion by bad water into the fresh water zone of the aquifer if the aquifer falls to or below record low levels. If there is such a risk, it is lessened by management of withdrawals from the aquifer. It is not erroneous to suggest that federal authorities may intervene in management of the aquifer in order to enforce the Endangered Species Act; to an extent, they have already done so. Nor is it erroneous to state that drought can create a threat to public health and safety. The staff agrees that pumping restrictions are not the only aquifer management technique available to the Authority; however, it would violate both the letter and the spirit of the Act for the Authority not to take steps to limit withdrawals from the aquifer during or in anticipation of critical periods. While protection of springflow-dependent habitat and species is one of the Authority's functions under the Act, there are several other important public interests that are served by protecting inflows of Edwards Aquifer water into the river systems downstream from the springs. The Act contemplates protection of Comal and San Marcos Springs irrespective of whether endangered species are involved.

Section 721.4 Effect on Demand Management Rules. One commenter stated that the public will be confused by the relationship between these rules and the Demand Management Rules previously adopted by the former Edwards Underground Water District.

Response. The staff does not believe that there will be any significant confusion. As stated in this section, these interim rules largely supersede the Demand Management Rules.

Section 721.5 Definitions. Various commenters stated that §721.5 should include definitions of the terms "agricultural," "athletic field," "playing field," "reuse," "recycle," and "waste."

Other commenters recommended that the definition of "landscape watering" be revised to add watering stations for wild game; and the definition of "supply" be revised to delete the phrase "without regard to the source from where the underground water is obtained" and to clarify that recycled, reclaimed, or reused water is not included.

Response. The staff does not believe that it is necessary for purposes of these rules to provide definitions for "agricultural" or "playing field." Staff agrees that the rules should include a definition of athletic field, and such a definition, adapted from the language suggested by the commenter, appears at §721.5(a)(3). Definitions of "reclaimed water," "recycled water" and "reused water" have been added as paragraphs (30), (31) and (33), respectively. Staff agrees that the concept of waste in the rules is important and should be defined in accordance with the Act. Subsection (a)(38) references the detailed definition of waste in §1.03 of the Act. After further review, the following definitions have also been added to §721.5 for the purpose of clarity: Irrigation Suspension Program (ISP), §721.5(a)(17); ISP Participant, §721.5(a)(19); J17 level, §721.5(a)(20); and reduction multiplier, §721.5(a)(32).

The 5-gallon limit for watering buckets in the definition of landscape watering is appropriate, consistent with a number of local ordinances, and should remain unchanged. The watering of wild game should not be added to the definition of "livestock"; to do so would add an unquantifiable and easily abused demand for water. Staff agrees with the comment concerning the definition of "supply," §721.5(a)(36) (proposed paragraph (28)), and has revised the definition to delete the reference to the source of the water. The definition of "supply" refers to "underground water," §721.5(a)(37) (proposed paragraph (29)) which is by definition water "within or produced, obtained, or originating from the Edwards Aquifer." The definition of "underground water" has been revised to make clear that it does not include recycled, reclaimed and reused water.

Section 721.5(a)(6) Definition of "Base Usage." A commenter stated that the definition of "base usage" in §721.5(a)(6) adversely impacts industrial users because there is no rational basis for applying the winter base usage period to such users. Industrial users operate at varying levels year round and changes in consumption are driven by demand for products or services and the vagaries of the business cycle. Another commenter made similar comments with respect to agricultural irrigation; according to the commenter, winter averaging is not a rational means of estimating essential use for irrigation, because such use is inherently seasonal and because sufficient information concerning past use is not available. A commenter also suggested that the base usage formula should be based on summer usage, not winter usage. Another commenter stated that including February 1996 in the base usage formula is inappropriate because Stage I and II of the Edwards Underground Water District's Demand Management Rules were in effect during that month.

Another commenter opposed the base usage concept altogether. The commenter stated that the base usage formula discourages conservation, encourages waste, penalizes those who conserve and does not provide an incentive to conserve. The commenter also stated that the base usage formula does not account for weather changes, previous years of drought plan implementation, regional growth, previous conservation efforts, or changes in per capita water use. The commenter suggested that the Authority should form a committee of diverse users to agree on an alternative methodology such as a 10-year rolling average by month which would be adjusted for the various factors listed above.

Response. Much industrial use is essential use and thus excepted from the reductions based on base usage. As to other industrial use, staff agrees that the base usage formula in the proposed rules may not account for seasonal or production-driven fluctuations in industrial or irrigation water demand. There is probably not a single base usage formula that can adequately address the water use patterns of all users. For this reason, §721.33 of the rules allows the general manager to utilize an alternative formula, with the approval of the board, to approximate better the minimum amount of underground water the user needs for essential uses or to avoid penalizing the user for development of alternative water supplies. An industrial user who believes that the base usage formula applied to functions irrationally or unfairly may file a variance request with the Board which proposes an alternative means of estimating base usage.

With respect to irrigation use, based on public comments and further review the staff believes that for purposes of these interim rules irrigation use should be considered an essential use which is not subject to maximum allowable usage limits. Irrigation use would still be subject to the rules' prohibitions against wasting water and allowing tailwater to escape from irrigated land, §721.42(1), (4). Section 721.32(a), relating to enforcement of maximum allowable usage limits, and §721.33(a), relating to calculation of base and maximum allowable usage by the general manager, have been revised to exclude irrigation use. The rules requiring the filing of base usage reports and monthly usage reports, §§721.51 and 721.52, have also been revised to exclude irrigation use from the filing requirement.

Winter usage is an appropriate estimator of essential water use for many users. Using a summer average to calculate base usage would obviously defeat the purpose of base usage. With respect to the use of February 1996 in the base usage formula, Stage II of the Demand Management Rules, the first mandatory stage, was declared on February 26, 1996, three days prior to the end of the month. February 1996 was unusually warm and dry, which resulted in relatively high usage for most users regardless of any reduction stages which were in place. The staff thus believes that it is reasonable to include February 1996 in the formula.

The staff believes that the winter-average base use formula in the adopted rule is a reasonable and workable technique for estimating essential uses, and provides a suitable basis for computing maximum allowable usage limits for most users. In the judgment of the staff, the ten-year rolling average base usage suggested by the commenter would not be an improvement. Such an approach could actually encourage more use during the outdoor watering season. Developing and implementing 10-year averages and adjusting those averages for the various factors identified by the commenter would also be considerably more complicated and difficult than the base usage formula adopted in the rules.

Section 721.5(a)(9) Definition of "Conjunctive User." One commenter recommended that the definition of "conjunctive user" be revised to make clear that conjunctive use involves integrated use of groundwater and surface water which obtains the most economical utilization of local storage resources and of distribution systems and the optimum amount of water conservation.

Response. The staff generally does not disagree with the language suggested by the commenter, but believes that the definition of conjunctive user should be broadly worded to encourage use of any alternative water supply, not just surface water. After further review, the proposed rule has been revised. Under the rule as adopted, "substantial" use of alternative water supplies means at least a 10% conversion to alternative water sources during the prior 12 months, and the first use of alternative water supplies must have occurred after 1986 to qualify the user or supplier for treatment as a conjunctive user.

Section 721.5(a)(12), (14) Definitions of "Discretionary Use" and "Essential Use." One commenter urged that watering of a golf course, and in particular a golf course at a hotel resort, ought to be defined as an essential use and thus excluded from required reductions under the rules, because the golf industry directly supports gainful employment. As proposed, all landscape watering is defined as a discretionary use, and is thus excluded from the definition of essential use. Similarly, another commenter recommended that the rules treat landscape watering as an essential use because a well-watered landscape reduces the risk of fire and reduces erosion, and because loss of landscape plants will cause economic harm. Other commenters suggested that golf courses, athletic fields, and cemeteries should be listed as discretionary uses. Another commenter stated that all non-wasteful water uses that affect property values or jobs should be considered non-discretionary, and that recreational use, landscape use, swimming pool use, and use for washing of parking lots should not be considered discretionary uses.

Response. The staff believes that it is appropriate for purposes of these rules to treat landscape watering, including the watering of golf courses, athletic fields, cemeteries, and other turf areas, as a discretionary use. The definition of discretionary use in adopted §721.5(a)(12) has been revised to clarify that "landscape watering, including residential, commercial and public landscapes, golf courses, athletic fields, and cemeteries" is considered discretionary use for purposes of these rules. The staff agrees that the golf industry generates significant economic value for the region and provides jobs. A separate section applicable to golf courses, §721.47, is adopted which recognizes the special water management needs of golf courses and encourages golf courses to utilize efficient irrigation systems and use alternative sources of water.

With respect to landscape watering, staff is not aware of any instance in which a residential or commercial landscape suffering from drought or watering restrictions was implicated in a structure fire. A well-maintained landscape, even in times of drought, should pose little threat of fire. A complete lack of vegetation does increase erosion, but the plan provides sufficient time to apply enough water to keep plants alive. Staff believes that persons in the Edwards Aquifer region should adopt a different style of landscaping that emphasizes drought tolerant ground cover and shrubs and minimizes the use of drought sensitive grass. Drought has and will continue to injure landscape plants, particularly those with water requirements that are ill-suited to this region. The landscape industry has the opportunity to supply the region's need for plants and turf that are adapted to the semi-arid climate of this region.

If water use restrictions are to be meaningful, the concept of "essential use" cannot be defined to include every use of water that has economic value or supports employment. If this were the case, the Authority could reduce discretionary water usage under these rules only by targeting fringe uses of water that are wasteful and non beneficial. Section 1.26 of the Act requires the Authority to distinguish between discretionary and nondiscretionary ("essential") uses, and to provide for the reduction in discretionary uses during critical periods to the maximum extent feasible. If reductions in discretionary uses are not sufficient, the Authority then must call for reductions in essential uses based on the prioritization of uses stated in §1.26(4) of the Act. Thus, in order to avoid or delay the day when essential uses must be curtailed, the Authority must be able to achieve significant reductions in water use by restriction of discretionary uses. From the standpoint of fair and effective regulation of water use, it would be counterproductive for the Authority to avoid the difficult choices involved in distinguishing between discretionary and essential uses.

Section 721.5(a)(16) Definition of "Industrial Use." Commenters stated that golf courses should be expressly listed as an industrial use, while another commenter stated that golf courses should be expressly excluded as an industrial use.

Response. It is not necessary for purposes of these rules to modify the definition of "industrial use" which appears in the Act and is restated in the rules to include or exclude golf courses. Even if the definition of industrial use expressly included golf courses, watering golf courses would still be treated under these rules as a "discretionary use" as that term is defined by paragraph (12).

Section 721.12 Exempt Wells and Essential Uses. One commented stated that this section should be clarified as to whether the exemption for essential uses of water in subsection (b) pertains only to owners of exempt wells or applies generally. Another commenter stated that this should also be made clear in subchapters D (relating to Maximum Allowable Usage and Enforcement), E (relating to Restrictions on Specific Uses), and F (relating to Reports).

Response. While there is value in separating exempt and essential uses into two sections, staff believes, at this time, it is appropriate to leave both items in the original section (721.12). The essential use provision is not directly germane to subchapter D or F, but can be restated in the interest of clarity in subchapter E. Section 721.41(b), as adopted, is added for this purpose.

Section 721.22 Critical Period Stages. One commenter argued that it is inconsistent for the Authority to develop a dry-year option plan for the purpose of reducing irrigation use in Medina County, based on the assumption that pumping in Medina County affects springflow at Comal Springs, while at the same time providing different critical period stage trigger levels for Medina County in §721.22 of these rules than are applied in the "East Area" by §721.21. Other commenters opposed

the different treatment of the East, Medina, and Uvalde areas for purposes of the critical period stages, arguing that all restrictions should be imposed regionwide and at the same time.

Response. Staff does not agree that there is an inconsistency between the different treatment between the East and Medina areas and the concept of the dry year option. It would be difficult if not impossible to calculate the exact correlation between pumping from a particular well in Medina County and springflow at Comal Springs, but there is no doubt that pumping from the Edwards Aquifer in Medina County in the aggregate affects the pressure and amount of water in the Aquifer and the flow of water at Comal Springs. It is also generally true that pumping in Medina County, simply as a function of distance from the springs, affects the springs less directly than pumping that occurs further to the East. Regulations cannot, and need not, model complex hydrological factors with exactitude, but it is reasonable and appropriate to take such factors into account. The same reasoning applies to the different treatment of the Uvalde Area; while the portion of the aquifer in Uvalde County is hydrologically linked to the portions of the aquifer to the East, distance and the hydrologic restriction called the Knippa Gap attenuate the rapidity and degree of effect that pumping in Uvalde County has on springflow.

Section 721.24 Beginning and End of Critical Period Stages. Several commenters complained that the trigger levels of the critical period stages as set out in the chart at §721.24(e), Figure 1, begin too late to protect springflow in a period of drought and declining aquifer levels, and will not ensure compliance with the Act's regionwide permitted withdrawal cap of 450,000 acre feet per year. The commenters stated that the trigger levels should be designed to reduce pumping before springflows at Comal Springs drop to the "take" level as determined by the United States Fish and Wildlife Service under the federal Endangered Species Act. Specifically, one commenter suggests that the trigger levels for Stages I through IV in the East area should be 260, 200, 175, and 100 cubic feet per second at Comal Springs, respectively, and that these trigger levels should correlate with well level triggers for Medina and Uvalde Areas. A commenter also stated that the reduction multipliers set out in the proposed Figure 1 chart, and in particular the 1.4 multiplier in Stages III and IV, are too high and should be lowered to further restrict water use.

In the opposite vein, another commenter complained that the trigger levels are much too high. The commenter maintained that there is no critical period until water levels fall below the historical average, and that no critical period stage should be triggered until springflow at Comal Springs falls to 60 cubic feet per second or the aquifer level falls to 628 feet above mean sea level at Well J-17. The commenter also complained that basing stage triggers on springflow at Comal Springs erroneously assumes that Comal Springs will go dry before San Marcos Springs.

Another commenter suggested that this section should be revised so that stages would be triggered based on a 10-day average since weekend pumping can trigger a lower stage, avoiding short cycles and needless confusion and cost. Another commenter stated that proposed Figure 1 of §721.24(d) (now §721.24(e)), which summarizes the critical period stages, trigger levels, and reduction multipliers, was not published in the Texas Register.

Response: The staff agrees that some adjustment in the trigger levels is appropriate. The trigger levels for the East area have been revised and are now expressed as aquifer level as measured as Well J-17 in San Antonio. Aquifer levels at Well J-17 are familiar to the public, and J-17 levels correlate well with springflow rates at Comal Springs. While springflow at San Marcos Springs does not correlate as well with Well J-17 as does springflow at Comal Springs, in general aquifer levels at Well J-17 are an excellent indicator of springflow and aquifer conditions in the Eastern portion of the aquifer.

In the adopted rule, the trigger levels for the East area (Counties of Bexar, Comal, Hays, Caldwell, and Guadalupe) are 650 feet mean sea level for Stage I, 642 feet mean sea level for Stage II, 636 feet mean sea level for Stage III, and 632 feet mean sea level for Stage IV. These triggers correlate reasonably well with Comal Springs springflow of 211, 179, 132, and 98 cubic feet per second, respectively. The triggers in the Medina Area (Counties of Medina and Atascosa) are 670 feet mean sea level for Stage I, 660 feet mean sea level for Stage II, and 655 feet mean sea level for Stage III, as measured at the Hondo Yard Well. The triggers in the Uvalde Area (County of Uvalde) are 845 feet mean sea level for Stage I and 840 feet mean sea level for Stage II, as measured at Well J-27 in Uvalde. The staff believes that these restated triggers will create an appropriate staging of critical period water use reductions. The triggers may be adjusted in the future based on analysis of data collected relating to how they affect aquifer levels during drought conditions and how they impact users. It is not realistic, however, to expect implementation of these critical period management rules, regardless of where the triggers are set, in and of itself to result in adequate springflows at all times. Nor is it appropriate to look to these rules to ensure compliance with the regional cap on permitted withdrawals. The cap will be implemented through the issuance and enforcement of withdrawal permits, development of alternative water supplies, and other water supply management measures.

In response to public comments and further review, staff has made an adjustment in one of the reduction multipliers listed in proposed Figure 1, §721.24(d). In the adopted rules, the reduction multipliers are listed both in Figure 1, which is incorporated into §721.24(e) and §721.24(d). Reduction multipliers are the factors that are multiplied by a user's base usage to calculate the user's maximum allowable usage. §721.31. In the proposed rules, the multiplier applicable in Stage IV, which applies only in the East Area of the Authority, would have been 1.4. In other words, under the proposed rules, water use in Stage IV was limited to 40% above the base usage. The adopted rule calls for a reduction multiplier of 1.3 (30% above base usage), with an adjusted reduction multiplier of 1.4 applicable to primary users who participate in funding the Authority's voluntary Irrigation Suspension Program. However, if the Irrigation Suspension Program is not implemented by the Authority, the board will determine the applicable Stage IV multiplier by order, in which case the multiplier cannot exceed 1.4 or be less than 1.2.

Section 721.24 has been revised to state that any critical period stage will remain in effect for at least ten days unless a more

restrictive stage is implemented. The proposed Figure 1 chart was published at 21 TexReg 8527 (Sept. 3, 1996), in the Tables and Graphics section of Volume II of that day's Register. The adopted Figure 1 chart, which has been revised, is being republished in the Tables and Graphics section of the Register. The chart is an integral part of §721.24. In order to avoid confusion, §721.24(d) has been revised to restate in text form the reduction multipliers that appear in Figure 1, and the text of proposed subsection (d) has been revised for clarity and moved to (e).

Section 721.32 Enforcement. A commenter suggested that the rules should provide 45 days between the date that a reduction stage goes into effect and application of enforcement penalties, because this delay will allow water suppliers time to give public notice, implement a surcharge, and establish a billing cycle. Another commenter stated that §721.32(c), which allows the Authority to mitigate enforcement for exceedances by a primary supplier based on non-preventable water main breaks, should be extended to other primary users that have substantial lengths of water mains that are also subject to breakage under drought conditions. Another commenter suggested that the Authority should take a user's size into account when seeking administrative or civil penalties for violation of these rules.

Response. The staff believes that providing a 45-day delay between stage declaration and application of enforcement penalties will defeat the purpose of the rules by allowing unabated water use during critical periods. Users and suppliers should develop and be prepared to implement surcharges and other necessary and appropriate measures well in advance of the declaration of a reduction stage. Users and suppliers should also stay abreast of water supply conditions in order to gauge when it may be necessary to implement critical period measures. In order to provide adequate notice to users and suppliers, §721.24(a) of the rules requires the general manager to post by 10:00 a.m. every business day the most recently available spring flow rates and water levels, as well as the 10-day rolling average of those numbers.

Staff recognizes that some primary users distribute water through water mains and that they may experience nonpreventable water main breaks in the same manner as primary suppliers. Section 721.32(c), however, appropriately applies only to primary suppliers, who typically have metered customer accounts. This section cannot address primary users distributing water through water mains subject to breakage unless end use by such users is also measured. Staff recommends that primary users who exceed their maximum allowable usage because of water main breaks or other unforeseen and unpreventable situations seek a variance under subchapter G or seek relief under the subchapter H relating to review and reconsideration of determinations of the general manager.

Sections 1.37 and 1.40 of the Act set out the limits of the administrative penalties the Authority may impose and the civil penalties the Authority may seek in court for violations of these rules. Enforcement decisions will be made on a case-by-case basis, and relative size of the violator may or may not be a relevant factor in a particular case.

Section 721.33 Determination of Base and Allowable Maximum Usage. A commenter recommended that the requirement for board approval in §721.33(b), which allows the general manager to calculate base usage or maximum allowable usage based on alternative criteria, should be deleted in order to avoid unnecessary delays. Other commenters stated that allowing the general manager to use alternative criteria may be unfair to some users and will not promote regionwide implementation of the rules, and that any formula to be used in calculating base or maximum allowable usage should be expressly stated in the rule. Another commenter stated that in order to avoid confusion, the word "primary" should be inserted in this subsection before "user," and the word "base" should be deleted where it appears before "essential use." Another commenter recommended that maximum allowable usage be adjusted to allow more water for landscape use by owners of large lots.

Response. The discretion conferred by §721.33(b) is appropriate because of the wide variations in water use patterns among users. The subsection, which requires board approval, promotes accountability and fairness when a modification is needed in the way base or maximum allowable usage is calculated. It would not be possible to anticipate in this rule all the possible sets of factors that might be appropriate for consideration in determining base or maximum allowable usage. With respect to large lots, staff does not believe that it is workable to key maximum allowable use to residential lot size. Further, landscape watering is treated as a discretionary use under these rules, and any substantial increase in this usage would likely have to be compensated for through reductions in essential uses.

Section 721.34 Determination of Maximum Allowable Usage of Conjunctive User. Several commenters complained that the formula for calculating base usage set out in the proposed section penalizes entities that have financed and developed alternative water supplies in order to reduce withdrawals from the aquifer, and that the rule should be revised to instead create incentives for development of alternative water supplies or enhancement of recharge. Some commenters recommended that a conjunctive user's base usage be calculated in a similar manner to other users, but that the calculation take into account all water used, regardless of the source. On the other hand, another commenter suggested that New Braunfels should not be allowed any favorable treatment as a conjunctive user because the Edwards Underground Water District helped finance New Braunfels' partial conversion to surface water. A commenter queried whether a conjunctive user could seek a different base usage formula through the general manager, §721.33(b), or through a variance, §§721.61-721.62. Other commenters recommended that in connection with proposed §721.34 credit should be given to entities that purchase sensitive sinkhole and cave properties, avoid plugging such features, or otherwise provide for enhanced recharge of the aquifer.

Response: Staff agrees that in some situations the proposed rule may have had the effect of not giving an entity that has developed alternative sources of water full credit for that development. The formula for determining base usage for a conjunctive user has been revised. Instead of using the proposed rule's summer-use based approach, the base usage for a conjunctive user is the average monthly total underground water usage for the three lowest months of November and December and the following January and February during

each of the three consecutive 12-month periods prior to the commencement of the user's use of non-Edwards Aquifer water. This winter-use based formula is designed to take into account the extent to which a conjunctive user has actually shifted demand for water to non-Edwards Aquifer sources. Staff points out that a conjunctive user is subject to the specific water use restrictions set out in subchapter E, §§721.41-721.48, to the same extent as any other user. In the view of staff, the rule as adopted encourages conjunctive water use and avoids penalizing entities that have invested in alternative supplies, but at the same time requires conjunctive users to bear a fair share of the burden of reducing aquifer use during critical periods.

Any user, including a conjunctive user, who believes that the applicable base usage formula does not reasonably approximate the user's essential water uses, or who believes that the applicable base usage or maximum allowable usage formula fails to give the user credit for development of alternative water supplies, may request the general manager to utilize, with board approval, alternative criteria for calculating these values. §721.33. The user may also seek review of the general manager's determination, §§721.71-721.72, and may request the board to grant a variance to avoid unusual, direct, and substantial hardship, §§721.61-721.62.

With respect to the suggestion of credits for beneficial acquisitions in the recharge zone, the staff believes that such credits are more appropriately dealt with under provisions of the Act governing water use permitting and conservation credits, rather than critical period management. The Authority has ample authority to promulgate rules such as envisioned by the commenter, but it would not be appropriate to do so in the context of these interim critical period management rules.

After further review, the staff has determined that the substance of proposed §721.34 is more logically included as part of the definition of "base usage" at §721.5(a)(6), and the substance of the proposed rule is transferred to that definitions section.

Section 721.41 Reduction Efforts. A commenter recommended that this section, which requires primary users to achieve maximum allowable usage levels at each critical period stage, should be revised to make clear that reductions are not required with respect to essential uses of water. Another commenter suggested in connection with subsection (c) of this section, that the Authority should require water purveyors to utilize conservation pricing at all times to help eliminate discretionary use and to impose on their residential customers a conservation fee for water use in excess of 267 gallons per day for a single family residence. Another commenter was generally opposed to allowing municipalities to exercise discretion with respect to implementation of water consumption management measures.

Response. It should be clear from §721.12(b)-(c) that essential uses as defined in §721.5(a)(14) are not subject to mandatory reductions. Nevertheless, staff has added a new subsection (b) to §721.41, which restates for clarity that essential uses are not subject to the reductions required by that section. Subsection (c) of §721.41 already requires suppliers to use inverted rate structures, conservation charges, critical period surcharges, and other programs to encourage water consumers to conserve, minimize waste, and reduce discretionary uses of water. The staff believes that water purveyors are generally in the best position to determine the most effective means of reducing consumption by their customers and meeting the applicable maximum allowable usage level. Further, imposing more specific requirements in these interim rules at this time might discourage purveyors from developing their own innovative approaches to consumption management.

Section 721.42 Stage I Restrictions. A commenter stated that paragraph (3) of this rule, which restricts the use of underground water to wash parking lots and other impervious outdoor ground coverings, should be modified to allow such washing when necessary for health or safety reasons. Another commenter recommended that §721.42(6), pertaining to swimming pools, be revised to require the covering of pools "with an effective evaporation cover or screen, or evaporative shields covering at least 25% of the surface of the pool, when the pool is not in active use." The rule as proposed required at least a 50% cover when the pool is not in active use between the hours of 10:00 a.m. and 8:00 p.m., based on the assumption that most evaporation occurs during the hottest part of the day. The commenter stated that wind is also a major contributor to evaporation, and that significant evaporation from swimming pools occurs during all 24 hours each day. Other commenters stated that §721.42(6) should be limited in applicability to private swimming pools because public, community and apartment pools are generally in use throughout the swimming season. Other commenters stated that the requirement of swimming pool covers will be difficult to enforce, and that the requirement should not be invoked until Stage II. A commenter stated that the phrase "recycling car wash" in paragraph (8) should be changed to "conservation car wash," and another commenter suggested that paragraphs (7) and (8) ought to be combined and revised to restrict car washing to commercial car washes.

Response: The staff agrees that washing of impervious outdoor ground surfaces should be permissible in the exceptional instances when it is necessary for health or safety reasons. Section 721.42(3) has been revised accordingly. Section 721.42(6), governing covering of swimming pools, has been revised to require effective covers, screens, or shields covering 25% of a pool's surface area at all times when a pool is not in active use or being maintained. The staff does not agree that this section should be limited to private swimming pools, but does agree that the covering requirement should be modified with respect to public, commercial, and apartment pools. The rule has thus been revised to state that with respect to these types of pools, "active use" means anytime the pool is not officially closed. This revision is justified by the heavy usage of public and quasi-public pools during the warm months of the year, and by the relatively small percentage of swimming pool water that is involved in such pools.

With respect to enforcement of the pool covering requirement, representatives of the swimming pool industry demonstrated inexpensive, lightweight, and unobtrusive swimming pool shields which float on the surface of the pool. These shields reduce evaporation in direct proportion to the percentage of the surface of the pool that is covered. Because many swimming pool owners pay a purveyor for their water, they have an economic incentive to reduce the amount of water they use to make up for pool evaporation. The staff believes that in this region use of some means of reducing evaporation from a swimming pool is

a reasonable pool management technique and should be used whenever practicable. Pool owners who fail to comply with the pool covering requirement will be subject to an enforcement action under §721.32(d) of the rules, which authorizes the recovery of administrative and civil penalties, among other remedies.

In accordance with the comment concerning paragraph (8), which pertains to car washes, the word "conservation" has been inserted before "car wash" in place of "recycling." Staff does not believe that car washing should be allowed only at commercial car washes. Staff is not aware of any data that suggests that washing a car at a commercial facility is more efficient than washing using a bucket of soapy water and a hand-held hose with nozzle on the lawn at home.

Sections 721.43-.45 Stages II-IV Designation of Watering Days. Paragraph (3) of each of these sections requires that municipalities designate their own watering days in Stages II, III, and IV, respectively. Paragraph (4) of each of these sections as proposed designated watering days for areas outside municipalities and areas within municipalities that have not designated their own watering days. A commenter stated that the word "must" in paragraph (3) of each of these sections, making it mandatory for municipalities to designate their own watering days, should be changed to "may" in keeping with paragraph (4), which provides in effect a default designation of watering days. Another commenter suggested that industrial users be allowed to designate their own watering days in order to avoid overtime costs and staffing problems. Another commenter stated that all landscape watering should occur on the same day throughout the region.

Response. The staff believes that these rules should continue to state that municipalities "must" designate their own watering days. This requirement encourages municipalities to consider what is best for their own residents with respect to what day or days should be designated for landscape watering. This requirement makes it unnecessary to set default watering days for municipalities, and paragraph (4) of §§721.43-721.45 has been revised accordingly. These sections have not been revised to allow industrial users to set their own watering days because the enforcement and administrative problems created by such a change would outweigh any benefit of convenience for individual industrial users. In exceptional cases, a variance may be available to an industrial user that shows that complying with the general watering days creates an undue hardship. With respect to the suggestion to require that all landscape watering occur on the same day, the staff points out that the rules are designed to give municipalities some discretion on watering days in order to accommodate their particular operating demands. Requiring all watering to occur on the same day would result in increased demand peaks on the aquifer.

Sections 721.43-721.45 Stages II-IV Restrictions on Landscape Watering. Paragraph (2) of these sections allows limited landscape watering "by means of a bucket (not to exceed 5 gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system." One commenter pointed out that §721.43(2) omits a reference to "soaker hose," stated that the phrase "drip irrigation" should be defined, and recommended that the phrase "properly installed" be expanded to maintenance and operation of drip irrigation systems. Other commenters stated that sprinkler systems are more efficient than hand watering and should be favored, that no sprinkling of landscape should be allowed in Stage IV, that watering by hand-held hose should be allowed at any time, and that watering by Authority-approved irrigation systems should be allowed at any time. Another commenter complained that the Stage IV limitation of landscape watering by bucket, hand-held or soaker hose, or drip irrigation system to the hours 7 a.m. and 11 a.m. on any day of the week, §721.45(2), is not sufficient time for people who work during the day to water their yards.

Response. The suggestion to add "soaker hose" to §721.43(2) is appropriate, and the section is revised accordingly. The staff does not believe that it is necessary at this time to define the phrase "drip irrigation." Because the term "properly installed" includes maintenance, and because wasteful use of water is expressly prohibited by §721.42(1) during any reduction stage regardless of the mode of application, it is not necessary to state here that a drip irrigation system must be properly operated. With respect to sprinkler systems, in some cases these systems may be more water-efficient than hand watering; however, many sprinkler systems are not installed or operated properly and many users or owners of such systems are prone to neglect proper maintenance. Banning the use of sprinkler systems in Stage IV would unfairly impact commercial building landscapes without providing a substantial benefit to the aquifer. Watering with a hand held hose at any time of the day is unacceptable. Evaporation and drift are greatest during the mid-day hours even if a hand-held hose is used. For the same reason, it would not be appropriate during these critical period stages to allow landscape irrigation at any time of day, even if the irrigation system is "approved." With respect to the Stage IV provision limiting landscape watering by bucket, hand-held or soaker hose, or drip irrigation system to the hours 7 a.m. and 11 a.m. on any day of the week, the staff believes that this is an adequate timeframe for most persons who work during the day.

Section 721.47 Golf Courses. Two commenters complained that this rule's restrictions on watering of golf courses is not stringent enough. One of these commenters doubted that the Authority would be able to monitor adequately evapotranspiration rates used by golf courses to control their water use, stated that the rules as proposed allow golf courses to increase their water use during times of drought, and proposed that as an alternative golf courses be allocated a limited amount of water per hole. Conversely, another commenter urged the Authority to adopt special treatment of resort hotels with golf courses, and complained that the restrictions imposed under Stages III and IV will threaten a golf resort's ability to maintain a first-class golf course and attract guests. The commenter suggested that golf resorts should never have to reduce their water replacement rate by more than 20%. Another commenter stated that the golf course rule is fair, manageable, and effective, but asked that the reduction percentage in Stage IV for conforming golf courses be changed from 35% to 30% to correlate with the maximum allowable usage limitation for that stage. Another commenter stated that §721.47(c) assumes that only golf courses without a computer controlled irrigation system are subject to being classified as non conforming.

Response. This rule, like the rule applicable to athletic fields, §741.48, is designed to be as stringent as possible without causing widespread loss of turf areas that support economic activity and employment. Staff realizes that under the rules golf course and athletic field watering may increase as a drought progresses and evapotranspiration rates increase. But under the rules, the rate of increase will be controlled and the total water used will be substantially less than in non-drought periods. The rules are designed to protect the substantial employment associated with golf tourism in the region and to protect the safety of players on athletic fields. According to superintendents and caretakers, considerable damage to golf courses and athletic fields may still occur. The staff believes that the golf course and athletic field rules strike an appropriate balance between demand management and economic and social considerations.

The staff does not agree that resort golf courses should be given special consideration and a distinct advantage over other private and public golf courses, all of which try to generate some revenue for profit or to cover expenses. The staff does agree, however, that the reduction percentage in Stage IV for conforming golf courses should be adjusted from 35% to 30% (or 20% for a conforming golf course that is a participant in the Authority's Irrigation Suspension Program), and §721.47(b)(2)(D) has been revised accordingly.

With respect to non-conforming golf courses under subsection (c), in order to be considered "conforming" a golf course must submit a use reduction plan within 30 days of the effective date of the rules as described in subsection (b). Among other things, such a plan must provide for use of a computer controlled irrigation system. A golf course that fails to timely file an adequate use reduction plan is considered "non-conforming." A golf course without a computer controlled irrigation system is non-conforming because it cannot meet the use reduction plan requirement of subsection (b). If the general manager disapproves the use reduction plan, the golf course will also be considered non-conforming. A golf course that develops the ability to qualify as a conforming golf course after the effective date of the rules may apply to the general manager for such treatment by submitting an adequate use reduction plan.

Section 721.48 Athletic Fields. A commenter expressed concern with respect to restrictions in watering of athletic fields under §721.48. The commenter stated that any further reductions in water use at its athletic fields will create unsafe playing conditions and may degrade the condition of the fields to such a point that they cannot be used. If this occurs, the commenter contends, the cost of restoring the fields to safe playing condition will be considerable. Another commenter suggested that conservation and reuse plans for athletic fields under this section should be subject to approval by the city, water supplier, or other entity with enforcement powers, and should be subject to review or revocation in Stage IV. The commenter also stated that watering of athletic fields should be defined as an essential use. Another commenter stated that there are inconsistencies between the administrative requirements of the plans required for golf courses and athletic fields.

Response: Athletic fields are treated separately in the plan from other landscapes in order to take into account the safety of event participants. A separate treatment for athletic fields is justified because such facilities are an integral component of educational curricula, and contribute to public health and safety. Athletic fields can become unsafe to athletes if not watered adequately. Section 721.48 was developed after considering comments and suggestions from grounds superintendents. The rule allows the owner or operator of an athletic field to submit to the Authority a conservation and reuse plan that provides for watering of the field in an amount not to exceed that which is "necessary to maintain the viability of the turf and maintain the turf in a safe condition." The rule thus addresses the commenter's concerns. In response to the comment concerning approval of athletic field conservation and reuse plans by a local authority, a new subsection (b)(10) is added to §721.48 which requires the owner or operator to state that the conservation and reuse plan does not conflict with any local regulations. In the judgment of the staff, it is unnecessary at this time to require the athletic field operator to obtain approval from another entity. The staff encourages athletic field operators and other users who submit conservation and reuse plans as authorized by these rules to work with local authorities to ensure compliance with ordinances and regulations. The staff believes that athletic fields, like other recreational turf areas, should continue to be treated as discretionary users of water under these rules, subject to the special provisions provided in §721.48. The staff believes that the rule adequately accommodates the economic, safety, and other factors.

With respect to the differences between the plan requirements for athletic fields and golf courses, the staff has reviewed these sections and believes that the plan requirements are appropriate and not inconsistent with one another. Both types of plan must be filed within 30 days of the effective date of these rules, and both must be approved or disapproved by the general manager within 30 days unless he or she requests additional information. The staff has not received information that owners of athletic fields like conforming golf courses should be required to utilize computer controlled irrigation systems and, if feasible, commit to obtaining alternate water supplies. Such measures may be further examined by staff in development of the comprehensive management plan and permanent critical period management rules.

Sections 721.51 and 721.52 Base Usage Reports and Monthly Usage Reports. A commenter recommended that proposed §721.52, which required weekly usage reports, be revised to require once-a-month water use summaries. Other commenters suggested that proposed §721.51(a)(3) should be deleted or revised to allow the use of well designations in lieu of a map. Another commenter stated that proposed §721.51(a)(5) should be revised to require reporting of the total amount of underground water withdrawn or supplied during the preceding 12 months. With respect to proposed subsection (a)(6) of both §721.51 and §721.52, which required reporting of the amount of water applied to essential uses, commenters stated that users can at best provide an estimate, and the rules should allow for estimates. A commenter recommended that proposed paragraph (7), which required reporting of amount of water applied to discretionary uses, be deleted. Another commenter stated that the subsection allowing the general manager to request additional information, proposed §§721.51(a)(11) and 721.52(a)(10), should limit such information by inserting the term "relevant." Other commenters suggested that subsection

(c) of §721.52 should provide for an administrative exception to the penalty for failure to timely file a weekly usage report, that there should be no weekly reporting requirement when stages are not in effect, and that the November 12, 1996 filing date for base usage reports should be extended.

Other commenters suggested that §721.52(a) be revised so that weekly reports are required to be filed only in the months of June, July, August and September or during Stage III-IV and that monthly reports be filed at all other times; that §721.52(a)(4) be revised to refer to "inclusive dates of the reporting period"; that the word "week" in §721.52(a)(8) should be replaced with "period," that §721.52(a)(9), which requires the user to summarize its efforts to conserve and reduce usage of underground water, is excessive and redundant and should be deleted; that monthly reports should be filed the day after the first weekday of the month; and that the last part of §721.52(c) should read "during the reporting period."

Response. The comment that water usage reports should be made on a monthly basis is well taken. Section 721.52 has been revised to require primary users to make monthly rather than weekly reports. These reports must be filed by the first Tuesday following the end of the calendar month which is the subject of the report. A water usage report must be filed for any calendar month during which a critical period stage was in effect at any time during the month. No water usage report is required for any calendar month in which no critical period stage was in effect, as determined by the Authority. The comments that expressed concerns with respect to weekly reporting under §721.52 are for the most part rendered moot by this change.

Section 721.51(a)(3), which required a weekly usage report to designate the location of all wells from which underground water was withdrawn, is deleted as unnecessary. Section 721.51(a)(5) has been reworded as suggested. The staff realizes that at this time many primary users and suppliers can only estimate the amounts of water applied to essential and discretionary uses by their customers. The word "estimated" has thus been inserted in §721.51(a)(6) and §721.52(a)(5) (proposed §721.52(a)(6)). The user or supplier should be prepared to demonstrate the manner in which the amounts were calculated, including any assumptions or formulas utilized. An estimated amount which is not calculated based on reasonably reliable data or is not trustworthy under the circumstances need not be accepted by the Authority. Proposed paragraph (7) has been deleted as unnecessary.

Adding the word "relevant" to proposed §§721.51(a)(11) and 721.52(a)(10) would invite disputes over what information is "relevant" for purposes of inclusion in base usage and monthly usage reports. The general manager has discretion to determine what information should be included in these reports. The staff agrees that failure to timely file a monthly usage report should not suspend the right to exclude exempt or essential uses from mandatory reductions if there is good cause for the failure, and §721.51(d) and §721.52(c) are revised accordingly.

Proposed section 721.51(b), which required primary users to file their base usage reports with the Authority by November 12, 1996, has been revised to required such filing within 30 days after the effective date of these rules. The effective date of the rules will be the 20th day following the date the adopted rules are filed with the Secretary of State. Texas Government Code, §2001.036(a).

Staff recommends no change to §721.52(a)(4) because it is sufficiently clear as written. "Reporting week" has not been changed to "reporting period," but instead has been changed to "reporting month" throughout the rule. Subsection (a)(9) of §721.52 has been deleted because it seeks information that is not critical to monitoring compliance with the rules. Due to the change to a monthly reporting format, §721.52(b) has been revised to require monthly usage reports to be filed by the 5th business day following the end of the reporting week.

Because some items have been deleted from subsections (a) of both §721.51 and §721.52, the items in that subsection have been renumbered in the adopted rule.

Section 721.61 Request for Variance. A commenter suggested that subsection (a) of this section be revised to read: "A person may file a request for variance from the Critical Period Management Rules of Chapter 721 with the Authority." Another commenter requested that subsection (a)(3) be revised to not require that the request for variance be acknowledged before a notary.

Response. The phrase "from these rules" has been added to §721.61(a) to clarify that the variance procedures described in this rule apply only to the Critical Period Management Rules. The acknowledgment requirement is not necessary, and has been removed from subsection (a)(3).

Subchapter A. General Provisions

31 TAC §§721.1–721.8

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.5. Definitions and Abbreviations.

(a) Definitions. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act - The act creating the Edwards Aquifer Authority (Senate Bill 1477, chapter 626, 73rd Legislature, Regular Session, 1993, as amended.

(2) Aquifer - The Edwards Aquifer, as defined in the Act.

(3) Athletic Field - A sports play field used primarily for organized sports for schools, professional sports or sanctioned league play whose essential feature is a grass turf.

(4) Authority - The Edwards Aquifer Authority.

(5) Authority offices - The principal offices of the Edwards Aquifer Authority, located in Bexar County, San Antonio, Texas, 1615 North St. Mary’s Street, Post Office Box 15830, 78212.

(6) Base usage - For a primary user who is not a conjunctive user, base usage shall mean the average monthly total underground water usage for the three lowest months of November and December of 1995 and January and February of 1996. For a primary user who is a conjunctive user, base usage shall mean the average monthly total underground water usage for the three lowest months of November and December and the following January and February during each of the three consecutive 12 month periods preceding the commencement of the primary user's use of the non-Edwards Aquifer water which qualifies the primary user as a conjunctive user.

(7) Beneficial use - The use of the amount of water that is economically necessary for a purpose authorized by law, when reasonable intelligence and reasonable diligence are used in applying the water to that purpose.

(8) Board - The board of directors of the Authority.

(9) Conjunctive user - A primary user shall be deemed a conjunctive user if:

(A) the user uses or supplies water other than underground water (for example, surface water or water from an aquifer other than the Edwards Aquifer) as a substantial portion of the total amount of water it used or supplied in the preceding 12 months;

(B) if the non-Edwards Aquifer water satisfies a demand that would otherwise be satisfied by Edwards Aquifer water;

(C) if the user uses or supplies all available non-Edwards Aquifer water first before using or supplying Edwards Aquifer water; and

(D) if the non-Edwards Aquifer water use considered with respect to determining the user's status as a conjunctive user was first used or supplied subsequent to 1986. For purposes of this definition, *substantial' shall mean at least 10%*.

(10) Day - A 24-hour period beginning at midnight.

(11) Demand Management Rules - The rules implementing the Demand Management Plan for the Edwards-Balcones Fault Zone Aquifer adopted by the Edwards Underground Water District on November 10, 1992, as revised.

(12) Discretionary use - Any use listed as follows or any other use of underground water that is not an essential use (compare with "essential use"), provided that use of underground water is essential and not discretionary to the extent the use is necessary to prevent danger to public health, safety, or welfare, or to comply with state or federal law:

(A) Recreational use to the extent the underground water is not recycled, including the watering of turf areas (see §721.47 and §721.48 of this title relating to Golf Courses and Athletic Fields).

(B) Landscape watering including residential, commercial and public landscapes, golf courses, athletic fields and cemeteries.

(C) Filling or maintaining swimming pools.

(D) Ornamental outdoor fountains and similar features.

(E) Washing of an impervious outdoor ground covering such as a parking lot, driveway, street, or sidewalk.

(F) Use in connection with an aquaculture operation, to the extent the underground water is not recycled.

(13) Domestic or livestock use - Use of underground water for:

(A) Drinking, washing, or culinary purposes;

(B) Irrigation of a family garden or orchard the produce of which is for household consumption only; or

(C) Watering of animals.

(14) Essential use - A use of water which is:

(A) Essential to the protection of public health, safety, or welfare, including but not limited to use for drinking, food preparation, personal hygiene, public sanitation, control or prevention of disease, and fire fighting; or

(B) Essential to an industrial use or agricultural or military activity which directly supports gainful employment, unless the use is specifically defined in these rules as a discretionary use; or

(C) Essential to irrigation use.

(15) General Manager - The general manager of the Authority.

(16) Industrial use - The use of water for or in connection with commercial or industrial activities, including manufacturing, bottling, brewing, food processing, scientific research and technology, recycling, production of concrete, asphalt, and cement, commercial uses of water for tourism, entertainment, and hotel or motel lodging, generation of power other than hydroelectric, and other business activities.

(17) Irrigation Suspension Program (ISP) – A program administered by the Authority pursuant to which agricultural irrigators within the Authority's boundaries voluntarily agree to suspend some irrigation use of the underground water from the Edwards Aquifer in consideration of payments voluntarily funded by ISP participants.

(18) Irrigation use - The use of water for the irrigation of pastures and commercial crops, including orchards.

(19) ISP Participant – Any beneficiary of the underground water who participates in an Irrigation Suspension Program by paying amounts to the Authority for the purpose of funding payments to irrigators to suspend some irrigation use of underground water.

(20) J-17 level – The level of the aquifer as measured by the Authority in Well J-17 (well number AY-68-37-203) in the City of San Antonio.

(21) J-27 level - The level of the aquifer as measured by the Authority in Well J-27 (well number YP69-50-302) in the City of Uvalde.

(22) Landscape watering - The application of underground water to grow or maintain plants such as flowers, ground covers, turf or grasses, shrubs, and trees, but for purposes of these rules does not include:

(A) Essential use without waste of underground water by a commercial nursery to the extent the water is used for production rather than decorative landscaping;

(B) Application of underground water without waste to a non-commercial family garden or orchard the produce of which is for household consumption only; and

(C) Application of underground water in the morning before 10:00 a.m. and in the evening after 8:00 p.m. by means of a bucket (not to exceed 5 gallons in capacity), hand-held hose, soaker hose, or properly-installed drip irrigation system, immediately next to a concrete foundation solely for the purpose of preventing, and to the extent the watering is necessary to prevent, substantial damage to the foundation or the structure caused by movement of the foundation.

(23) Livestock - Animals, beasts, or poultry collected or raised for pleasure, recreational use, or commercial use. The term includes but is not limited to cattle, sheep, goats, swine, horses, chickens, turkeys, and zoo animals, but does not include fish or other aquatic animals raised in a tank, raceway, reservoir, or watercourse.

(24) Maximum allowable usage - The maximum allowable usage of underground water that a person is allowed to withdraw or supply as provided in §§721.31 - 721.33 of this title (relating to Maximum Allowable Usage; Enforcement; and Determination of Base and Maximum Allowable Usage).

(25) Medina well level - The level of the Aquifer as measured by the Authority in the Hondo Yard Well (well number TD-69-47-306).

(26) Person - An individual, corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, and any other legal entity.

(27) Primary supplier - A primary user that supplies more than 25,000 gallons of underground water per day in accordance with §721.11 of this title (relating to Primary Users).

(28) Primary user - Any person who withdraws or supplies more than 25,000 gallons of underground water per day in accordance with §721.11 of this title (relating to Primary Users).

(29) Produce - To withdraw underground water.

(30) Reclaimed water - Domestic wastewater that is under the direct control of the treatment plan owner/operator which has been treated to a quality suitable for a beneficial use.

(31) Recycled water - Water that is used by the same person two or more times sometimes with partial treatment in between uses.

(32) Reduction multiplier - A multiplier specified in §721.24(d) and (e), Figure 1 of this title (relating to Critical Period Stages), which is used to calculate a primary user's maximum allowable usage depending on the applicable critical period reduction stage.

(33) Reused water - Water that remains unconsumed after the water is used for the original purpose of use and that is used again before the water is discharged or otherwise allowed to flow into a watercourse, lake, or other body of state-owned water.

(34) Springflow rate - The rate of flow, in cubic feet per second (c.f.s.), from Comal Springs in New Braunfels, Comal County, Texas, as measured by the United States Geological Survey.

(35) Supplier - Any person that supplies underground water, including but not limited to a public or private water company, a water supply corporation, a municipality or water district.

(36) Supply - To provide, sell, or transfer underground water to another person for any purpose and without regard to the manner in which the underground water is obtained, delivered, transported, or transferred to the other person, pursuant to a contract or otherwise.

(37) Underground water - Water within or produced, obtained, or originating from the Edwards Aquifer. Recycled, reclaimed and reused water are specifically excluded from this definition.

(38) Waste - For the purposes of this chapter, the term "waste" shall have the same meaning as defined in the Edwards Authority Act, Chapter 626, §1.03 relating to definitions, subsection (21).

(39) Watering day - A day designated for landscape watering, limited to the morning hours from midnight to 10:00 a.m. and the evening hours from 8:00 p.m. to midnight. Thus, if Saturday is a designated watering day, the period of time referenced is Saturday morning between 12:00 a.m. to 10:00 a.m., and Saturday evening between 8:00 p.m. and midnight.

(40) Withdraw - To effect, cause, suffer, allow or permit a withdrawal. For purposes of these rules, any person who owns, leases, or has actual or constructive possession of a producing well or the land upon which the well is located withdraws from that well.

(41) Withdrawal - An act or a failure to act that results in taking of water from the Edwards Aquifer by or through man-made facilities, including pumping, withdrawing, or diverting underground water.

(b) Abbreviations. The following abbreviations apply to this chapter:

(1) C.f.s. - Cubic feet per second.

(2) Ft. m.s.l. - Feet above mean sea level.

(3) ISP - Irrigation Suspension Program.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 28, 1997.

TRD-9701302
Rick Illgner
General Manager
Edwards Aquifer Authority
Effective date: February 18, 1997
Proposal publication date: September 3, 1996
For further information, please call: (210) 222–2204

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Subchapter B. Applicability of Rules

31 TAC §721.11, §721.12

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.12. Exempt Wells and Essential Uses.

(a) With regard to exempt wells, no person is required to reduce withdrawals of underground water from any well that produces 25,000 gallons of underground water per day or less; however, owners of such wells are strongly encouraged to follow the requirements for landscape watering of individuals served by municipal or public water supply systems.

(b) With regard to essential uses, no person is required to reduce the amount of underground water withdrawn or supplied to the extent the water is used for an essential use, as defined in §721.5(a)(14) of this title (relating to Definitions).

(c) This section does not relieve any person of the duty to reduce the amount of underground water actually applied to discretionary uses to the maximum extent feasible as may be necessary to comply with the applicable maximum allowable usage, or the duty to comply with specific restrictions mandated by §§721.42 - 721.48 of this title (relating to Stage I Restrictions; Stage II Restrictions; Stage III Restrictions; Stage IV Restrictions; Use Necessary for Public Health or Safety; Golf Courses; and Athletic Fields).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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General Manager
Edwards Aquifer Authority
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Subchapter C. Critical Period Stages

31 TAC §§721.21–721.24

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.21. Critical Period Stages-East Area .

These critical period stages apply to all primary users located within the boundaries of the Authority that are in the counties of Bexar, Comal, Hays, Caldwell, and Guadalupe:

(1) Stage I. Stage I applies on any day following a day when the J-17 level is at or below 650 ft. m.s.l. and above 642 ft. m.s.l.

(2) Stage II. Stage II applies on any day following a day when the J-17 level is at or below 642 ft. m.s.l. and above 636 ft. m.s.l.

(3) Stage III. Stage III applies on any day following a day when the J-17 level is at or below 636 ft. m.s.l. and above 632 ft. m.s.l.

(4) Stage IV. Stage IV applies on any day following a day when the J-17 level is at or below 632 ft. m.s.l.

§721.22. Critical Period Stages-Medina Area.

These critical period stages apply to all primary users located within the boundaries of the Authority that are in the counties of Medina and Atascosa, when the Medina well level reaches the following levels:

(1) Stage I. Stage I applies on any day following a day when the Medina well level is at or below 670 ft. m.s.l. and above 660 ft. m.s.l.

(2) Stage II. Stage II applies on any day following a day when the Medina well level is at or below 660 ft. m.s.l. and above 655 ft. m.s.l.

(3) Stage III. Stage III applies on any day following a day when the Medina well level is at or below 655 ft. m.s.l.

§721.23. Critical Period Stages-Uvalde Area.

These critical period stages apply to all primary users located within the boundaries of the Authority that are in the County of Uvalde, when the J-27 level reaches the following levels:

(1) Stage I. Stage I applies on any day following a day when the J-27 level is at or below 845 ft. m.s.l. and above 840 ft. m.s.l.

(2) Stage II. Stage II applies on any day following a day when the J-27 level is at or below 840 ft. m.s.l.

§721.24. Beginning and End of Critical Period Stages.

(a) The general manager will post by 10:00 a.m. every business day the most recently available springflow rate and well levels, as well as the 10-day rolling average of those rates or levels and the applicable critical period stage as established by §§721.21 - 721.24 of this title (relating to Critical Period Stages-East Area; Critical Period Stages Medina Area; Critical Period Stages-Uvalde Area; and Beginning and End of Critical Period Stages).

(b) If springflow rate or a well index is not available on a particular day, the stage in effect in the applicable area will continue to the next day.

(c) A critical period stage will remain in effect for at least ten days unless a more restrictive stage is implemented and otherwise will not be rescinded until the 10-day rolling average of the applicable well index triggers a less restrictive stage. (For example, if Stage III is in effect in the East area of the Authority, Stage II cannot be triggered in that area until the 10-day rolling average of the J-17 level rises above 636 ft. m.s.l.).

(d) The reduction multipliers for each stage are as follows: Stage I: 1.8; Stage II: 1.6; Stage III: 1.4; and Stage IV: 1.2, 1.3, or 1.4, as applicable. In the event the Authority implements an Irrigation Suspension Program for 1997, the maximum allowable usage in Reduction Stage IV shall be 1.3 times base usage for all users except ISP participants, and the maximum allowable usage in Stage IV for ISP participants shall be 1.4 times base usage. In the event

the Authority does not implement an Irrigation Suspension Program for 1997, the maximum allowable usage in Stage IV shall be set by order of the Authority not later than April 10, 1997, and in any event shall be no lower than 1.2 nor higher than 1.4.

(e) The well levels which trigger stages as described in this section and the applicable reduction multipliers are stated in Figure 1, which is incorporated herein. Stages are triggered independently in each of the three areas.
Figure 1: 31 TAC 721.24(e)

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 28, 1997.

TRD-9701300
Rick Illgner
General Manager
Edwards Aquifer Authority
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Proposal publication date: September 3, 1996
For further information, please call: (210) 222–2204

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Subchapter D. Maximum Allowable Usage and Enforcement

31 TAC §§721.31–721.33

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26. 721.31. Maximum Allowable Usage. Maximum allowable usage is the product of the base usage times the reduction multiplier assigned to each reduction stage. The stages and reduction multipliers are shown in §721.24(e), Figure 1, of this title (relating to Beginning and End of Critical Period Stages).

§721.31. Maximum Allowable Usage.

Maximum allowable usage is the product of the base usage times the reduction multiplier assigned to each reduction stage. The stages and reduction multipliers are shown in §721.24(e), Figure 1, of this title (relating to Beginning and End of Critical Period Stages).

§721.32. Enforcement.

(a) Subject to §721.12 of this title (relating to Exempt Wells and Essential Uses), primary users other than irrigation users are prohibited from withdrawing or supplying more than the applicable maximum allowable usage during each critical period stage.

(b) This prohibition will be enforced by the Authority to the fullest extent permitted by law beginning on the effective date of these rules.

(c) Notwithstanding any other provision to the contrary, the Authority will base an enforcement action for exceedances of a primary supplier's maximum allowable usage on metered sales rather than the amount of water supplied as provided in §721.11 of this title (relating to Primary Users) if the primary supplier demonstrates that:

(1) the exceedance is due to non-preventable water main breaks that are caused by weather conditions during the critical period;

(2) the primary supplier's unaccounted-for water is less than 20% of total water pumped or does not exceed 25 million gallons per day, whichever is lower;

(3) the primary supplier demonstrates to the satisfaction of the Authority that it implements and maintains an aggressive leak detection program; and

(4) the primary supplier demonstrates that it exercises reasonable diligence in detecting, repairing, and preventing such breaks.

(d) A person that violates any term or provision of these rules may be assessed an administrative penalty or subject to a civil suit in state district court for an injunction or civil penalties brought by the Authority to enforce these rules as provided for in the Act, §§1.36, 1.37, 1.38 and 1.40.

§721.33. Determination of Base and Maximum Allowable Usage.

(a) The general manager will initially determine the base usage and maximum allowable usage for each primary user, other than an irrigation user, based on the base usage report and other data available to the Authority. The general manager will notify primary users of the determinations in writing.

(b) The general manager, with the approval of the board, may calculate base or maximum allowable usage on different criteria than is otherwise required by these rules in particular cases, in order to better approximate the minimum amount of underground water the primary user needs for essential uses or to avoid penalizing the user for development of alternative water supplies.

(c) Notwithstanding subsection (a) of this section, primary users have the duty to self-determine their base usage and maximum allowable usage, and are subject to the prohibitions contained in §721.32 of this title (relating to Enforcement) regardless of whether the general manager has determined such amounts or notified the primary user of such determinations.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Rick Illgner
General Manager
Edwards Aquifer Authority
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Subchapter E. Restrictions on Specific Uses

31 TAC §§721.41–721.48

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.41. Reduction Efforts.

(a) Primary users shall achieve the maximum allowable usage level at each critical period stage by conserving underground water, minimizing waste, reducing discretionary uses of underground water to the maximum extent feasible, and taking any other necessary steps to reduce use of underground water.

(b) No person is required to reduce the amount of underground water withdrawn or supplied to the extent the water is used for an essential use as defined in §721.5(a)(14) of this title (relating to Definitions and Abbreviations).

(c) Primary suppliers shall make timely and effective use of inverted rate structures, conservation charges, critical period surcharges, and other programs to encourage water consumers to conserve underground water, minimize waste, comply with specific restrictions, utilize high-efficiency water systems such as low-flow toilets and shower heads, and reduce discretionary uses of underground water to the maximum extent feasible.

§721.42. Stage I Restrictions.

When Stage I is in effect, the following restrictions apply to all persons throughout the applicable area of the Authority:

(1) No person may waste underground water.

(2) No person may use underground water for landscape watering between the hours of 10:00 a.m. and 8:00 p.m. This subsection does not apply to non-potable water, graywater, and treated effluent.

(3) No person may use underground water to wash an impervious outdoor ground covering such as a parking lot, driveway, street, or sidewalk unless for health or safety reasons.

(4) No person may allow irrigation tailwater to escape from that person's land.

(5) Restaurants and other eating establishments are prohibited from serving underground water to customers except upon request of the customer.

(6) Every person who owns or has possession of a swimming pool must cover the pool with an effective evaporation cover or screen, or evaporation shields covering at least 25% of the surface of the pool, when the pool is not in active use. Active use includes necessary maintenance that requires removal of the cover, screen, or shields. Active use of public, commercial and apartment pools is whenever the pool is not officially closed.

(7) No person may wash an automobile at a residence except on a watering day designated by these rules or by a municipality pursuant to these rules, and in no event may a person allow underground water from automobile washing at a residence escape into the street or otherwise off the person's property.

(8) Charity car washes are prohibited except at a commercial car wash that recycles at least 75% of the underground water it uses or that is certified as a conservation car wash by a municipality or other political subdivision.

§721.43. Stage II Restrictions.

When Stage II is in effect, the following restrictions apply to all persons throughout the applicable area of the Authority:

(1) All of the prohibitions applicable in Stage I apply in Stage II.

(2) No person may use underground water for landscape watering on more than two watering days in any calendar week, except that landscape watering is permitted on any day before 10:00 a.m. and after 8:00 p.m. by means of a bucket (not to exceed 5 gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system. This subsection does not apply to non-potable water, graywater, or treated effluent.

(3) Municipalities must designate specific watering days on which persons within their jurisdictions are allowed to use underground water for landscape watering, in accordance with this section. Municipalities are encouraged to stagger such days so as to reduce peaks of demand.

(4) For all persons whose property is outside of a municipality, the watering days are Saturday and Wednesday.

(5) No person may use underground water for an ornamental outdoor fountain or similar feature, unless the water is recycled and the only additional underground water used for the feature is to compensate for evaporative losses.

§721.44. Stage III Restrictions.

When Stage III is in effect, the following restrictions apply to all persons throughout the applicable area of the Authority:

(1) All of the prohibitions applicable in Stage I apply in Stage III.

(2) No person may use underground water for landscape watering on more than one watering day in any calendar week, except that landscape watering is permitted to maintain shrubs, trees, and other ornamental plants, but not grass or turf, on any day before 10:00 a.m. and after 8:00 p.m. by means of a bucket (not to exceed 5 gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system. This subsection does not apply to non-potable water, graywater, or treated effluent.

(3) Municipalities must designate a specific day or days of the calendar week on which persons within their jurisdictions are allowed to use underground water for landscape watering, in accordance with this section. Municipalities are encouraged to stagger such days so as to reduce peaks of demand.

(4) For all persons whose property is outside of a municipality, the watering day is Saturday.

(5) No person may use underground water for an ornamental outdoor fountain or similar feature.

§721.45. Stage IV Restrictions.

When Stage IV is in effect, the following restrictions apply to all persons throughout the applicable area of the Authority:

(1) All of the prohibitions applicable in Stage I and §721.44(5) of this title (relating to ornamental outdoor fountains and similar features) apply in Stage IV.

(2) No person may use underground water for landscape watering on more than one watering day in any calendar week. For purposes of this subsection, "watering day" is limited to the morning hours of 3:00 a.m. to 7:00 a.m., and the evening hours of 8:00 p.m. to 11:00 p.m. However, landscape watering by means of a bucket (not to exceed five gallons in capacity), hand-held or soaker hose, or properly-installed drip irrigation system is permitted to maintain trees, shrubs, and other ornamental plants, but not grass or turf, on any day of the week during the morning hours of 7:00 a.m. to 11:00 a.m. Persons utilizing irrigation systems requiring more than seven hours to complete one weekly watering cycle may request a variance in accordance with §721.61 of this title (relating to Requests for Variances). Such a request must be accompanied by a conservation and reuse plan for the irrigation system. This subsection does not apply to non-potable water, graywater, or treated effluent.

(3) Municipalities must designate a specific day or days of the calendar week on which persons within their jurisdictions are allowed to use underground water for landscape watering, in accordance with this section. Municipalities are encouraged to stagger such days so as to reduce peaks of demand.

(4) For all persons whose property is outside of a municipality, the watering day is Saturday.

(5) Filling of all new and existing swimming pools is prohibited, unless at least 30% of the water is obtained from a source other than the Edwards Aquifer. Underground water may be used to replenish swimming pools to maintenance level. Drainage of swimming pools is permitted only onto a pervious surface, or onto a pool deck where the water is transmitted directly to a pervious surface, only if necessary to:

(A) remove excess water from the pool due to rain in order to lower the water to the maintenance level;

(B) repair, maintain, or replace a pool component which has become hazardous; or

(C) repair a pool leak.

§721.47. Golf Courses.

(a) Other provisions of these rules to the contrary notwithstanding, golf courses shall be divided into two categories:

(1) Conforming Golf Course - means a golf course that has filed a Golf Course Use Reduction Plan with the general manager within thirty days after the effective date of these rules pursuant to subsection (b) of this section.

(2) Non-conforming Golf Course - means a golf course that is not a conforming golf course.

(b) Reduction Plan Requirements - In order to be approved by the general manager, a Use Reduction Plan must be filed within 30 days of the effective date of these rules and, at a minimum, comply with the following:

(1) Contain a plan with projected implementation dates to convert to an alternate water supply to reduce and eliminate consumption of underground water to the maximum extent feasible. This conversion may incorporate the use of a purveyed reuse or recycled water system (evidenced by a letter of commitment from a purveyor) and/or the golf course must participate in the Irrigation Suspension Program; and

(2) Provide methods of achieving enhanced conservation by utilizing a computer controlled irrigation system ("CCIS"), comprised of a computer controller (digital operating system), software, interface modules, satellite, field controller, soil sensors, weather station, or similar devices, which is capable of achieving maximum efficiency and conservation in the application of water to the golf course. A CCIS, at a minimum, should be designed to prevent overwatering, flooding, pooling, evaporation and run-off; and prohibit sprinkler heads from applying water at an intake rate exceeding the soil holding capacity. The plan must require the user to accomplish the following reductions:

(A) Stage I - 10% reduction in the replacement of daily evapotranspiration rate ("ET rate") or daily soil holding capacity.

(B) Stage II - 20% reduction in the replacement of daily ET rate or daily soil holding capacity.

(C) Stage III - 30% reduction in the replacement of daily ET rate or daily soil holding capacity; provided that if the user is an ISP participant, the required reduction shall be 20%.

(D) Stage IV - 30% reduction in the replacement of daily ET rate or daily soil holding capacity; provided that if the user is an ISP participant, the required reduction shall be 20%.

(3) The reduction plan shall be approved or disapproved, or the general manager shall request additional information within 30 days of the filing of the plan. The reduction plan shall be subject to at least an annual review by the general manager.

(c) Non-conforming Golf Course - shall comply with the following reduction measures:

(1) Stage I - 10% reduction in the replacement of daily ET rate as monitored by a properly operating CCIS or use of not more than 1.8 times the base usage for golf courses that are not equipped with a CCIS.

(2) Stage II - 20% reduction in the replacement of daily ET rate as monitored by a properly operating CCIS or use of not more than 1.6 times the base usage for golf courses that are not equipped with a CCIS.

(3) Stage III - 30% reduction in the replacement of daily ET rate as monitored by a properly operating CCIS or use of not more than 1.4 times the base usage for golf courses that are not equipped with a CCIS .

(4) Stage IV - 40% reduction in the replacement of daily ET rate as monitored by a properly operating CCIS or use of not more than 1.3 times the base usage for golf courses that are not equipped with a CCIS.

§721.48. Athletic Fields.

(a) An owner or operator of an athletic field who files a conservation and reuse plan in compliance with this Section with the Authority within 30 days after the effective date of these rules, may apply underground water to the field in accordance with this section if the general manager approves the plan. Athletic fields that are not covered by an approved conservation and reuse plan must comply with all maximum allowable and specific restrictions provided in this chapter.

(b) A conservation and reuse plan for athletic fields must contain the following information:

(1) The name, title, address, and telephone number of the owner or operator of the athletic field;

(2) the name, title, address, and telephone number of the person(s) responsible for the watering of the field;

(3) whether the field is public or private, and the populations served by the field;

(4) the location, dimensions, type of athletic field, and type of turf;

(5) a description of the water-delivery system used and how and when it is used;

(6) a description of management practices relating to watering the field that are employed to control the amount of water applied to the field;

(7) a description of any turf areas that are not essential to the functioning of the field that are or could be watered in accordance with the specific restrictions on landscape watering contained in this chapter;

(8) a statement of what the owner or operator believes is a minimum amount of water and a minimum watering regimen during critical periods that applies only the amount of water necessary to maintain the viability of the turf without creating a safety hazard to users of the field;

(9) a statement of any actions or plans to obtain alternative water supplies such as reuse water, and if applicable a copy of any letter of commitment from a water purveyor regarding supplying such water to the field;

(10) a statement that the conservation and reuse plan is also in compliance with any local conservation plans;

(11) Any other information required by the general manager.

(c) The general manager shall either approve or disapprove the conservation and reuse plan or request additional information within 30 days of the date of filing.

(d) The general manager shall approve the conservation and reuse plan if the general manager is satisfied that the plan meets the following criteria:

(1) It contains all necessary information and documentation.

(2) The plan provides for a critical period watering regimen that uses only the amount of underground water necessary to maintain the viability of the turf and maintain the turf in a safe condition.

(3) The plan provides that underground water will be applied to areas that are not essential to the use of the field in accordance with the applicable maximum allowable usage and specific restrictions imposed by this chapter.

(4) If non-potable water is available or may be available to the field within five years, the owner or operator is committed to making use of such non-potable water for watering of athletic fields as soon as practicable.

(e) The general manager may require the revision of a conservation and reuse plan or require the owner or operator to provide additional or updated information, and may disapprove a plan previously approved if it appears that the plan no longer meets the criteria set forth in subsection

(d) of this section.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Rick Illgner
General Manager
Edwards Aquifer Authority
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For further information, please call: (210) 222–2204

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Subchapter F. Reports

31 TAC §721.51, §721.52

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.51. Base Usage Reports.

(a) Every primary user, other than an irrigation user, must file a base usage report with the Authority which contains the following information, to the extent the information is available:

(1) the person's name, address, and telephone number;

(2) contact person and title;

(3) the location and name or number of all wells from which underground water is withdrawn (attach map);

(4) the monthly amount of underground water withdrawn or supplied during the months of November and December of 1995 and January and February of 1996, or for conjunctive users, the monthly amount of underground water withdrawn or supplied during the months of November and December and the following January and February during each of the three consecutive 12-month periods preceding the commencement of the primary user's use of the non-Edwards Aquifer water which qualifies the primary user as a conjunctive user.

(5) the total amount of underground water withdrawn or supplied each month during the 12 months prior to the date of the report, and the total amount of underground water withdrawn for such months.

(6) the estimated amount of water actually beneficially applied without waste to essential uses, and the nature of such uses;

(7) the identification of any well that the person claims as an exempt well in connection with §721.12 of this title (relating to Exempt Wells and Essential Uses);

(8) a summary of the person's past efforts to conserve water and reduce the amount of water required, and the efficacy of such efforts;

(9) a summary of any actions the person intends to take to conserve water and reduce the amount of water required in order to comply with these rules; and

(10) any other information requested by the general manager.

(b) A primary user must file its base usage report with the Authority within 30 days after the effective date of these rules.

(c) A person who becomes a primary user after the effective date of these rules must file a base usage report within seven days of the first day the person becomes a primary user.

(d) A person who, without good cause, fails to timely file a complete base usage report in accordance with this section is not entitled to exclude underground water from mandatory reductions under §721.12 of this title (relating to Exempt Wells and Essential Uses) until a base usage report is filed with the Authority.

(e) Forms for filing the base usage report will be available from the Authority.

§721.52. Monthly Usage Reports.

(a) Each primary user, other than an irrigation user, must file monthly usage reports with the Authority for any month during which a stage is in effect. These reports must contain the following information to the extent the information is available:

(1) the person's name, address, and telephone number; (2) contact person and title;

(3) the reporting month;

(4) total amount of underground water withdrawn or supplied during the reporting month;

(5) the estimated amount of underground water applied to essential use during the reporting month, and the nature of such use;

(6) any other information requested by the general manager.

(b) Monthly usage reports must be filed with the Authority no later than the fifth business day of the month following the reporting month.

(c) A primary user who, without good cause, fails to timely file a monthly usage report in accordance with this section is not entitled to exclude underground water from mandatory reductions under §721.12 of this title (relating to Exempt Wells and Essential Uses) for the reporting month.

(d) The general manager may in special cases arrange for different reporting requirements under this section, including less frequent reporting.

(e) Forms for filing the monthly usage report will be available from the Authority.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Rick Illgner
General Manager
Edwards Aquifer Authority
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Subchapter G. Variances

31 TAC §§721.61–721.65

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

§721.61. Request for Variance.

(a) A person may file a written request for a variance from these rules with the Authority. The request must contain the following information:

(1) the specific nature of the variance requested;

(2) a detailed explanation of why the person believes it should be granted the variance, including any supporting documentation;

(3) a statement that the facts contained in the request are true and within the person's personal knowledge.

(b) The general manager or the board may request the person to provide additional information, which must be filed within 10 days of the request or as otherwise directed in the request.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Rick Illgner
General Manager
Edwards Aquifer Authority
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For further information, please call: (210) 222–2204

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Subchapter H. Review and Reconsideration

31 TAC §721.71, §721.72

The Authority adopts these new rules pursuant to its general and special powers under the Edwards Aquifer Authority Act (the "Act"), chapter 626, 73rd Legislature, Regular Session, 1993, as amended, §§1.08, 1.11, 1.14, 1.17, 1.26, 1.35, 1.36, 1.37, 1.38, 1.40 and 1.41, and chapter 36 of the Texas Water Code.

The adopted sections implement the Edwards Aquifer Authority Act, chapter 626, 73rd Legislature, Regular Session (1993), as amended, §§1.11, 1.14, and 1.26.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Rick Illgner
General Manager
Edwards Aquifer Authority
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For further information, please call: (210) 222–2204

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TITLE 34. PUBLIC FINANCE

Part I. Comptroller of Public Accounts

Chapter 3. Tax Administration

Subchapter A. General Rules

34 TAC §3.9

The Comptroller of Public Accounts adopts an amendment to §3.9, concerning the electronic transmission of payments to the state by certain taxpayers, without changes to the proposed text as published in the November 26, 1996, issue of the *Texas Register* (21 TexReg 11439).

The amended section lowers the threshold amount of the requirement to transmit payments electronically to the comptroller to $250,000 annually from $500,000.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Tax Code, Title 2.

The amendment implements the Government Code, §404.095(c) and (f) and Tax Code, §112.051.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 29, 1997.

TRD-9701364
Martin Cherry
Chief, General Law
Comptroller of Public Accounts
Effective date: February 19, 1997
Proposal publication date: November 26, 1996
For further information, please call: (512) 463–3699

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

Part IX. Commission on Jail Standards

Chapter 300. Fees

Collection of Fees

37 TAC §300.5

The Texas Commission on Jail Standards adopts an amendment to § 300.5, concerning Fees, without changes to the proposed text as published in the November 29, 1996 issue of the *Texas Register* (21 TexReg 11576).

The reasoned justification for this rule is that the Commission determined from testimony of the Commission staff that the staff has been experiencing difficulty performing the primary functions of the Commission on Jail Standards, that is the function designated in Texas Government Code §511.009, with the existing rule requiring the Commission to send invoices within 10 days. Analysis by Commission staff indicated that the invoice could still be sent to the municipalities or counties within a reasonable time after services were rendered and that the deletion of the 10 day requirement would allow staff to maintain compliance with the Commission's primary function. The Commission further reasoned that invoicing was secondary to its primary duties. Thus the Commission reasoned that adoption of this rule will allow the Commission to effectively invoice municipalities and counties within an adequate time constraint.

This rule deletes the requirement that an invoice be sent within 10 days to a municipality or county for services rendered.

No comments were received.

The amendment is adopted under Government Code, Chapter 511 which provides the Texas Commission on Jail Standards with the authority to revise, amend, or change rules and procedures if necessary.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on January 31, 1997.

TRD-9701439
Jack E. Crump
Executive Director
Commission on Jail Standards
Effective date: February 21, 1997
Proposal publication date: November 29, 1996
For further information, please call: (512) 463-5505

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TABLES & GRAPHICS

Graphic material from the emergency, proposed, and adopted sections is published separately in this tables and graphics section. Graphic material is arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic material is indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word “Figure” followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on. Multiple graphics in a rule are designated as “Figure 1” followed by the TAC citation, “Figure 2” followed by the TAC citation.

Figure 1. 31 T.A.C. 721.24(e)

J-17 Well Level	Medina Well Level	J-27 Level	Reduction Stage	Maximum Allowable Usage [1]
650	670	845	I	1.8 x base usage
642	660	840	II	1.6 x base usage
636	655	---	III	1.4 x base usage
632	---	---	IV	1.2, 1.3, or 1.4 x base usage See <*>721.24(d)

[1]See definition of base usage, maximum allowable usage, and reduction multiplier in <**> 721.5(a)(6), (24), (32) and 721.31 of this title (relating to Definitions and Maximum Allowable Usage).

OPEN MEETINGS

Agencies with statewide jurisdiction must give at least seven days notice before an impending meeting. Institutions of higher education or political subdivisions covering all or part of four or more counties (regional agencies) must post notice at least 72 hours before a scheduled meeting time. Some notices may be received too late to be published before the meeting is held, but all notices are published in the ***Texas Register***.

Emergency meetings and agendas. Any of the governmental entities listed above must have notice of an emergency meeting, an emergency revision to an agenda, and the reason for such emergency posted for at least two hours before the meeting is convened. All emergency meeting notices filed by governmental agencies will be published.

Posting of open meeting notices. All notices are posted on the bulletin board at the main office of the Secretary of State in lobby of the James Earl Rudder Building, 1019 Brazos, Austin. These notices may contain a more detailed agenda than what is published in the ***Texas Register***.

Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have an equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting summary several days prior to the meeting by mail, telephone, or RELAY Texas (1-800-735-2989).

State Office of Administrative Hearings

Thursday, March 27, 1997, 10:00 a.m.

1701 North Congress Avenue

Austin

Utility Division

AGENDA:

A Hearing on the Merits will be held at the above date and time in SOAH DOCKET Number 473–97–0060–COMPLAINT OF JOE HOLMES AGAINST TEXAS UTILITIES ELECTRIC COMPANY (PUC DOCKET Number 16650).

Contact: J. K. Trostle, 300 West 15th Street, Suite 502, Austin, Texas 78701–1649, (512) 936–0728.
Filed: February 4, 1997, 11:18 a.m.

TRD-9701544

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Texas Commission for the Blind

Friday, February 14, 1997, 8:30 a.m.

4800 North Lamar, Criss Cole Rehabilitation Center, Administrative Conference Room

Austin

Governing Board Audit Committee

AGENDA:

1. Discussion: Status of current projects

2. Discussion and action: Prioritization of projects

Contact: Diane Vivian, P.O. Box 12866, Austin, Texas 78711, (512) 459–2601.
Filed: February 5, 1997, 9:47 a.m.

TRD-9701602

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Friday, February 14, 1997, 9:30 a.m.

4800 North Lamar, Criss Cole Rehabilitation Center, Administrative Conference Room

Austin

Governing Board

AGENDA:

1. Introductions

2. Public comments

3. Approval: Minutes from Board meeting of November 15, 1996

New Business

4. Discussion and action: Executive Director's report on first quarter activities

5. Report: Status of BEP Manual

6. Report: New facilities in the Business Enterprises Program

7. Report: Services to older blind Texans

8. Report: Status of Children's Program Manual

9. Report: Transition Program

10. Report: Status on NFB Newsline

11. Report: Private outside vendors competing for establishment grants

12. Discussion: Establishment of a Board Business Enterprises Program Committee

13. Discussion and action: Addition of an Impartial Hearing Officer

14. Discussion and action: board Committee Report— Audit Committee

15. Executive session pursuant to Chapter 551 of the Government Code to discuss personnel and pending or contemplated litigation with attorney

16. Action, if required, on matters discussed in executive session

17. Date and location of next regular meeting.

Contact: Diane Vivian, P.O. Box 12866, Austin, Texas 78711, (512) 459–2601.
Filed: February 5, 1997, 9:47 a.m.

TRD-9701601

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Texas Bond Review Board

Tuesday, February 11, 1997, 10:00 a.m.

Clements Building, Committee Room Five, Fifth Floor, 300 West 15th Street

Austin

Planning Session

AGENDA:

I. Call to Order

II. Approval of Minutes

III. Discussion of Proposed Issues

A. Texas General Land Office- lease purchase of computer equipment and software

B. Texas Water Development Board- State Revolving Fund Senior Lien Revenue Bonds, Program Series 1997

C. Texas A&M University System- Revenue Financing System Refunding Bonds, Series 1998

D. Texas A&M University System- Revenue Financing System Bonds, Series 1997

IV. Other Business — Discussion of legislative action/schedules

V. Adjourn

Contact: Albert L. Bacarisse, 300 West 15th Street, Suite 409, Austin, Texas 78701, (512) 463–1741.
Filed: February 3, 1997, 2:55 p.m.

TRD-9701517

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Texas Department of Commerce

Wednesday, February 12, 1997, 1:00 p.m.

1700 North Congress Avenue, Room 118

Austin

Policy Board

AGENDA:

1:00 p.m. Call to order; Recess into Executive Session; Call back to order; Adoption of the minutes from the meeting of November 13, 1996; Election of Vice Chair of the Policy Board; Report from Executive Director; Legislative Update; Update on International Activities; Presentation of the Smart Jobs Fund Grants Awarded through November 30, 1996; Report of the TSBIDC Investment Transactions; Update on Tourism Activities; Overview of commerce role in State School-to-Work Initiative; Consider the Final Adoption of Texas Department of Commerce Policy Board Investment Policy Rules; Consider the Final Adoption of the Texas Leverage Fund Program Rules 10 TAC §§181.1–181.10; Public comments; Board Comments; Adjourn.

Contact: Shirley Zimmerman, 1700 North Congress Avenue, Austin, Texas 78701, (512) 936–0158.
Filed: February 3, 1997, 4:55 p.m.

TRD-9701528

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State Board of Dental Examiners

Friday, February 14, 1997, 8:00 a.m.

333 Guadalupe, Tower Two, Second Floor HPC Conference Room

Austin

Board

AGENDA:

I. Call to Order

II. Roll Call

Discussion and a vote may be called for on all items under the following headings:

III. Review and Approval of Past Minutes

IV. Rules- Discuss and consider final adoption of rules 103.3, 107.102, 107.300, 109.107, 109.141, 109.44, 109.2, 109.211, 109.91, 115.2, 116.2, 116.3, 116.4, 116.5, 116.20, 116.22, 116.24, 116.25, 117.1, 119.3.

V. Appearance Before the Board: Abbott, Daniels, Kindler, Ward

VI. Licensing and Examination: Credentials Committee report; licensure by credentials applications for dentists and dental hygienists; dedation-anesthesia permits; Legislative Committee rpoet; Dental Hygiene Advisory Committee rport; Dental Laboratory Certification Council report.

VII. Enforcement- Discuss, consider and vote on settlement conference orders

VIII. Administration – Discuss Budget; Transfer of peer assistance fees; squarterly performance report; agency manuals; survey of organizational excellence reports

IX. President and Executive Director's Report

X. General Counsel's Report

XI. Executive Session to discuss, if necessary, items posted herein pursuant to Govt. Code 551.071 (Vernon Supp. 1996) and to discuss Personnel Matters pursuant to Tex. Govt Code 551.074, Vernon Supp. 1996) evaluation of Executive Director and General Counsel; discuss Anderson vs Wise, et al, cause number 9700813, 189th Judicial District Court, Harris County, Texas; Discuss Mitchmore vs. TSBDE, cause number 53, 803, 253rd Judicial District Court, Liberty County, Texas

XII. Election of Officers

XIII. Public Comments

XIV. Announcements

XV. Adjourn

Contact: Mei Ling Clendennen, SBDE Offices, 333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78791,
Filed: February 3, 1997, 3:00 p.m.

TRD-9701519

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Texas Education Agency (TEA)

Tuesday, February 18, 1997, 1:30 p.m.

1701 North Congress Avenue, William B. Travis Building, Room 1–104

Austin

Texas Ed-Flex Committee

AGENDA:

This is a regular meeting of the Texas Ed-Flex Committee. The agenda is as follows: (1) call to order; (2) approval of minutes; (3) recommendations on specific district and campus waiver requests; (4) recommendations on statewide waivers; (5) review of annual report to the United States Department of Education on Ed-Flex; (6) discussion of assistance for recipients of programmatic waivers; (7) discussion of waivers applicable to the state education agency; (8) status report; and (9) adjourn.

Contact: Madeleine Draeger Manigold, 1701 North Congress Avenue, Austin, Texas 78701, (512) 463–9077.
Filed: February 5, 1997, 8:20 a.m.

TRD-9701582

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Texas Department of Health

Friday, February 14, 1997, 10:00 a.m.

Main Building, Room G-107, Texas Department of Health, 1100 West 49th Street

Austin

Children with Special Health Care Needs (CSHCN) Advisory Committee, Conference Call

AGENDA:

The committee will introduce new committee members and discuss and possibly act on: new non-consumer members' terms; Texas Department of Health update (Texas Healthy Kids; Children's Health Insurance Plan (CHIP) transition team activities; Chronically Ill and Disabled Children's Services Program (CIDC) update; Medically Dependent Children Program (MDCP) proposed rules (25 TAC, Chapter 34); Title V objective for (CSHCN); web site listing; Senate Bill 118; and any other bills of interest). The committee will have a working lunch beginning at noon and will discuss and possibly act on: Star Plus initiative; South Texas Center to study CSHCN; Families Are Valued Project report; future agenda items; announcements; and public comments.

To request an accommodation under the ADA, please contact Lonzo Kerr, ADA Coordinator in the Office of Civil Rights at (512) 458–7627 or TDD at (512) 458–7708 at least two days prior to the meeting.

Contact: Paula Russell, 1100 West 49th Street, Austin, Texas 78756, (512) 458–7700, extension 3046.
Filed: February 5, 1997, 10:00 a.m.

TRD-9701607

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Texas Statewide Health Coordinating Council

Saturday, February 15, 1997, 11:30 a.m.

The St. Anthony Hotel, 300 East Travis Street

San Antonio

AGENDA:

The council will have a working luncheon with its Subcommittee on Texas Performance Review to discuss and possibly act on HHS35; and submission of recommendations to the council

To request an accommodation under the ADA, please contact Suzzanna Currier, ADA Coordinator in the Office of Civil Rights at (512) 458–7627 or TDD at (512) 458–7708 at least two days prior to the meeting.

Contact: Gregg Ukaegbu, 1100 West 49th Street, Austin, Texas 78756, (512) 458–7261.
Filed: February 4, 1997, 3:16 p.m.

TRD-9701565

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Saturday, February 15, 1997, 11:30 a.m.

The St. Anthony Hotel, 300 East Travis Street

San Antonio

AGENDA:

The council will discuss and possibly act on: White Paper on local health departments and hospital closures and/or reconfigurations; Legislative Committee meeting report; Texas Department of Health's legislative proposals for the 75th Session of the Texas Legislature; report of the Subcommittee on Texas Performance Review; and a new planning cycle.

To request an accommodation under the ADA, please contact Suzzanna Currier, ADA Coordinator in the Office of Civil Rights at (512) 458–7627 or TDD at (512) 458–7708 at least two days prior to the meeting.

Contact: Gregg Ukaegbu, 1100 West 49th Street, Austin, Texas 78756, (5120 458–7261.
Filed: February 4, 1997, 3:16 p.m.

TRD-9701567

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Saturday, February 15, 1997, 1:00 p.m.

The St. Anthony Hotel, 300 East Travis Street

San Antonio

Legislative Committee

AGENDA:

The committee will discuss and possibly act on: White paper on local health departments and hospital closures and/or reconfigurations; Texas Department of Health's legislative proposals for the 75th

Session of the Texas Legislature; legislative reports; and setting the next meeting time and proposed agenda.

To request an accommodation under the ADA, please contact Suzzanna Currier, ADA Coordinator in the Office of Civil Rights at (512) 458–7626 or TDD at (512) 458–7708 at least two days prior to the meeting.

To request an accommodation under the ADA, please contact Suzzanna Currier, ADA Coordinator in the Office of Civil Rights at (512) 458–7626 or TDD at (512) 458–7708 at least two days prior to the meeting.

Contact: Gregg Ukaegbu, 1100 West 49th Street, Austin, Texas 78756, (5120 458–7261.
Filed: February 4, 1997, 3:16 p.m.

TRD-9701566

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Board of Law Examiners

Thursday, February 13, 1997, 8:30 a.m.

Suite 500, Tom C. Clark Building, 205 West 14th Street

Austin

Panel Hearings

AGENDA:

The hearings panel will hold public hearings and conduct deliberations; including the consideration of proposed agreed orders, on the character and fitness of the following applicants, declarants and/or probationary; Trent Howell; David Perwin; Katherine Rabe, Gregory Kline; Sonja Thompson-Penn; Allyson Wilkinson; Ali Ahmed; Jeffrey Mullins, (character and fitness deliberations may be conducted in executive session, pursuant to §82,993(a), Texas Government Code).

Contact: Rachael Martin, P.O. Box 13486, Austin, Texas 78711–3486, (512) 463–1621.
Filed: February 4, 1997, 8:16 a.m.

TRD-9701531

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Texas Department of Licensing and Regulation

Thursday, February 13, 1997, 9:00 a.m.

920 Colorado, E.O.Thompson Building

Austin

Enforcement Division, Air Conditioning

AGENDA:

According to the complete agenda, the Department will hold an Administrative Hearing to consider possible assessment of administrative penalties against the Respondent, Ernesto Torres Olivares, for failing to maintain insurance requirements in violation of 16 Texas Administrative Code (TAC) 75.40(b) and failing to furnish the Department with a certificate of insurance in violation of the Texas Revised Civil Statutes Annotated, Articles 8861 (the Act) §3B, pursuant to the Act and Texas Revised Civil Statutes Annotated Article 9100, the Texas Government Code, Chapter 2001 (APA) and 16 TAC Chapter 75.

Contact: Paula Hamje, 920 Colorado, E.O. Thompson Building, Austin, Texas 78701, (512) 463–3192.
Filed: February 3, 1997, 4:26 p.m.

TRD-9701525

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Texas Lottery Commission

Tuesday, February 4, 1997, 11:30 a.m.

6937 North IH35, American Founders Building, First Floor Auditorium

Austin

EMERGENCY MEETING AGENDA:

According to the agenda, the Texas Lottery Commission will call the emergency meeting to order; executive session to consider the appointment, employment, and duties of an Acting Executive Director; return to open session for further discussion and possible action involving the appointment, employment, and duties of an Acting Executive Director; and, adjourn.

For ADA assistance, call Michelle Guerrero at (512) 323–3791 at least two days prior to meeting.

REASON FOR EMERGENCY: The unanticipated and unforeseen resignation of the Acting Executive Director. The resignation was submitted late in the afternoon of February 3, 1997, to be effective at 5:00 p.m. February 3, 1997. In the absence of a person acting in the capacity of an Executive Director neither statute or agency regulation provides for a successor with lawful authority to conduct the day-to-day business of the agency.

Contact: Michelle Guerrero, 6937 North IH35, Austin, Texas 78752, (512) 323–3791.
Filed: February 3, 1997, 6:18 p.m.

TRD-9701529

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Texas Natural Resource Conservation Commission

Wednesday, February 12, 1997, 2:00 p.m.

Room 201S, Building E, 12100 Park 35 Circle

Austin

AGENDA:

This meeting is a work session for discussion between Commissioners and staff. No public testimony or comment will be accepted except by invitation of the Commission.

Contact: Doug Kitts, 12100 Park 35 Circle, Austin, Texas 78753, (512) 239–3317.
Filed: February 4, 1997, 2:34 p.m.

TRD-9701555

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Board of Nurse Examiners

Tuesday, February 11, 1997, 9:00 a.m.

333 Guadalupe Street, Tower 3, Suite 460

Austin

Eligibility and Disciplinary Committee

EMERGENCY REVISED AGENDA:

The Eligibility and Disciplinary Committee of the board will meet to consider: the Petition for Reinstatement of Licensure for Suzanne M. Behringer, petitioner, 511888.

REASON FOR EMERGENCY: Ms. Behringer was inadvertently omitted from the agenda filed on January 31, 1997. License number 526539 was inadvertently omitted from Cheryl E. Pruns, Petitioner, which was filed on January 31, 1997.

Contact: Cheryl Sepulveda, Box 140466; Austin, Texas 78714, (512) 305–6824.
Filed: February 4, 1997, 9:22 a.m.

TRD-9701535

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Texas Public Finance Authority

Wednesday, February 12, 1997, 10:30 a.m.

William P. Clements Building, 300 West 15th Street, Conference Room 904C, 9th Floor

Austin

Board

AGENDA:

1. Call to order.

2. Approval of Minutes of January 15, 1997 Board Meeting.

3. Report regarding the Superconducting Supercollider defeasance project.

4. Discussion of proposed legislation.

5. Consider procedures for the appointment of an Executive Director and related matters.

6. Executive Session to consider applications for the position of Executive Director in accordance with Texas Government Code, §551.074.

7. Other busines.

8. Adjourn.

Persons with disabilities, who have special communication or other needs, who are planning to attend the meeting should contact Jeanine Barron or Marce Watkins at (512) 463–5544. Requests should be made as far in advance as possible.

Contact: Jeanine Barron, (512) 463–5544, 300 West 15th Street, Suite 411, Austin, Texas 78701.
Filed: February 4, 1997, 9:22 a.m.

TRD-9701536

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Railroad Commission of Texas

Tuesday, February 11, 1997, 9:30 a.m.

1701 North Congress Avenue, First Floor Conference Room 1–111

Austin

AGENDA:

Commission consideration and action on the state-funded plugging of wells for American Eagle Resources, Inc.

Contact: Joe Mayorga, P.O. Box 12967, Austin, Texas 78711–2967, (512) 463–6831.
Filed: February 3, 1997, 4:18 p.m.

TRD-9701524

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Texas State Soil and Water Conservation Board

Wednesday, February 12, 1997, 10:00 a.m.

101 South Main, Room 304, W.R. Poage Federal Building

Temple

USDA-Natural Resources Conservation Service (Texas State Technical Committee)

AGENDA:

9:00 a.m.— Registration

10:00 a.m.—Introduction

Review actions of September 5, 1996 meeting

Review of Conservation Reserve Program

Working lunch — Dutch Treat

Review of Environmental Quality Incentives Program

Review of Wetland Reserve Program

Review of Wildlife Habitat Incentives Program

2:30 p.m.— Adjourn

Contact: John P. Burt, 101 South Main, Temple, Texas 76501, (817) 298–1228, fax: (817) 298–1388.
Filed: February 4, 1997, 8:15 a.m.

TRD-9701530

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Teacher Retirement System of Texas

Monday, February 3, 1997, 3:00 p.m.

1000 Red River, Fifth Floor Boardroom

Austin

Board of Trustees Real Estate Committee

EMERGENCY MEETING AGENDA:

1. Consideration of Restructure or Disposition of Deficiency Notes (Secured by Partnership Interests Relating to Trammell Crow Center) as a Condition to Proposed Sale of Trammell Crow Center Note and Mortgage.

REASON FOR EMERGENCY: In order to consummate the sale of the Trammell Crow Center Note and Mortgage, immediate action is required to approve an additional condition of sale which also involves the Deficiency Notes. The additional condition of sale was imposed recently and was unforeseen. It will be difficult or

impossible to get a quorum of the Committee at one location due to the schedules of the Committee members.

Contact: John R. Mercer, 1000 Red River, Austin, Texas 78701–2698, (512) 397–6400.
Filed: February 3, 1997, 12:56 p.m.

TRD-9701515

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Texas Board of Veterinary Medical Examiners

Monday, February 12, 1997, 9:30 a.m.

William P. Hobby Building, 333 Guadalupe, Tower 3, Room 302

Austin

Examination Preparation Committee

AGENDA:

The Committee will meet to prepare the April, 1997 State Board Examination for licensure.

Contact: Judy Smith, 333 Guadalupe, Room 2–330, Austin, Texas 78701, (512) 305–7555.
Filed: February 4, 1997, 4:11 p.m.

TRD-9701577

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Monday, February 12, 1997, 12:30 p.m.

William P. Hobby Building, 333 Guadalupe, Tower 3, Room 302

Austin

Rules Committee

AGENDA:

The Committee will meet to study and discuss the applicable rules and statutes to be considered when reviewing petitions to waive examination requirements for licensure.

Contact: Judy Smith, 333 Guadalupe, Room 2–330, Austin, Texas 78701, (512) 305–7555.
Filed: February 4, 1997, 4:12 p.m.

TRD-9701578

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Texas Workforce Commission

Tuesday, February 11, 1997, 9:00 a.m.

Room 644, TWC Building, 101 East Fifteenth Street

Austin

AGENDA:

Prior meeting notes; Public Comment; Staff reports, update on activities relating to Skills Development Fund and other activities as determined by the Acting Executive Director; Consideration and action on tax liability cases listed on Texas Workforce Commission Docket 7; Discussion, consideration and possible action regarding potential and pending applications for certification and recommendations to the Governor of local workforce development boards for certification; Discussion, consideration and possible action regarding recommendations to TCWEC of strategic and operational plans submitted by local workforce development boards; Executive session pursuant to Tex. Govt. Code §551.074 to discuss personnel matters with executive staff and pursuant to Government Code §551.071 to discuss J. Eugene Crawford vs. TEC Case Number 394–CV-734–R, U.S. District Court, Northern District, Dallas Division; and Gracia S. Dukes vs. TEC and Alice Braun in Her Individual Capacity Only, Civil Action Number A-95–CA43JN, U.S. District Court, Western District, Austin Division, and other pending litigation; Actions, if any, resulting from executive session; Consideration and action on whether to assume continuing jurisdiction on Unemployment Compensation cases and reconsideration of Unemployment Compensation cases, if any; Consideration and action on higher level appeals in Unemployment Compensation cases listed on Texas Workforce Commission Docket 7; and Set date of next meeting.

Contact: Esther Hajdar, 101 East Fifteenth Street, Austin, Texas 78778, (512) 463–7833.
Filed: February 3, 1997, 4:00 p.m.

TRD-9701522

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Regional Meetings

Meetings filed February 3, 1997

Bexar-Medina-Atascosa Counties Water Control and Improvement District One, Board of Directors met at 226 State Highway 132, Natalia, at 8:30 a.m. Information may be obtained from John Ward, P.O. Box 170, Natalia, Texas 78059, (210) 665–2132. TRD-9701520.

Brazos River Authority, Board of Directors, met at Cooper Aerobics Center, 12230 Preston Road, Dallas, February 9, 1997, at 1:00 p.m. Information may be obtained from Mike Bukala, P.O. Box 7555, Waco, Texas 76714–7555, (817) 776–1441. TRD-9701527.

Brazos River Authority, Board of Directors, met at Cooper Aerobics Center, 12230 Preston Road, Dallas, February 10, 1997 at 8:00 a.m. Information may be obtained from Mike Bukala, P.O. Box 7555, Waco, Texas 76714–7555, (817) 776–1441. TRD-9701526.

Capital Area Planning Council, Executive Committee, will meet at 2520 IH35 South, Suite 100, Austin, February 12, 1997, at noon. Information may be obtained from Richard G. Bean, 2520 IH35 South, Suite 100, Austin, Texas 78704, (512) 443–7653. TRD-9701514

Central Appraisal District of Nolan County, Board of Directors, will meet at 119 East Third Street, Sweetwater, February 11, 1997 at 7:00 a.m. Information may be obtained from Patricia Davis, P.O. Box 1256, Sweetwater, Texas 79556, (915) 235–8421. TRD-9701518.

Falls County Appraisal District, Agricultural Advisory Board, met at Intersection of Highway 7 and Business 6, Falls County Courthouse, First Floor, Marlin, February 10, 1997 at 5:30 p.m. Information may be obtained from Joyce Collier, P.O. Box 430, Marlin, Texas 76661, (817) 883–2543. TRD-9701516.

Permian Basin Regional Planning Commission, Board of Directors, will meet at 2910 La Force Boulevard, Midland, February 12, 1997 at 1:30 p.m. Information may be obtained from Terri Moore, P.O. Box 60660, Midland, Texas 79711, (915) 563–1061. TRD-9701521.

Meetings filed February 4, 1997

Bexar-Medina-Atascosa Counties Water Control and Improvement District, # One, Board of Directors, met at 226 State Highway

132, Natalia, February 10, 1997 at 8:30 a.m. Information may be obtained from John Ward, P.O. Box 170, Natalia, Texas 78059. TRD-9701556.

Blanco County Appraisal District, Board of Directors, will meet at 200 North Avenue G, Johnson City, at noon. Information may be obtained from Hollis Boatright, P.O. Box 338, Johnson City, Texas 78636. TRD-9701554.

Colorado County Appraisal District, Board of Directors, will meet at 400 Spring, Grand Jury Room, Columbus, February 11, 1997, 1:30 p.m. Information may be obtained from Billy Youens, P.O. Box 10, Columbus, Texas 78934, (409) 732–8222. TRD-9701532.

Canyon Regional Water Authority, Board of Managers, met at Guadalupe Fire Training Facility, 850 Lakeside Pass Drive, New Braunfels, February 7, 1997 at 3:30 p.m. Information may be obtained from Gloria Kaufman, 850 Lakeside Pass, New Braunfels, Texas 78130–8233, (210) 609–0543. TRD-9701543.

Canyon Regional Water Authority, Regular Board, met at Guadalupe Fire Training Facility, 850 Lakeside Pass Drive, New Braunfels, February 10, 1997, 7:00 p.m. Information may be obtained from Gloria Kaufman, 850 Lakeside Pass, New Braunfels, Texas 78130–8233, (210) 609–0543. TRD-9701542

Capital Area Planning Council, Executive Committee, will meet at 2520 IH35 South, Suite 100, Austin, February 12, 1997, 12:00 p.m. Information obtained from Richard G. Bean, 2520 IH35 South, Suite 100, Austin, Texas 78704, (512) 443–7653.TRD-9701545.

Cypress Springs Water Supply Corporation, Special Meeting, met at the Office of Cypress Springs Water Supply Corporation, Highway 115, South of Mount Vernon, February 10, 1997 at 7:00 p.m. Information may be obtained from Richard Zachary, P.O. Box 591, Mount Vernon, Texas 75457, (903) 860–3400. TRD-9701538.

Cypress Springs Water Supply Corporation, Board of Directors Meeting, met at the Office of Cypress Springs Water Supply Corporation, 4430 Highway 115, South of Mount Vernon, February 11, 1997 at 7:00 p.m. Information may be obtained from Richard Zachary, P.O. Box 591, Mount Vernon, Texas 75457, (903) 860–3400. TRD-9701539.

Dallas Housing Authority, Dallas Housing Authority Board of Commissioners, will meet at the Melrose Hotel, 3015 Oaklawn Avenue, Dallas, February 13, 1997 at 8:00 a.m. Information may be obtained from Betsy Horn, 3939 North Hampton Road, DAllas, Texas 75212, (214) 951–8302. TRD-9701540.

222nd Judicial District Community, Judicial Council, will meet at 235 East Third Street, Third Floor Courthouse, Hereford, February 14, 1997 at 5:00 p.m. Information may be obtained from Larry Sheffield, 235 East Third, Room 204, Hereford, Texas 79045, (806) 364–3791. TRD-9701568.

Red Bluff Water Power Control District, Board of Directors, met at 111 West Second Street, Pecos, February 10, 1997 at 1:00 p.m. Information may be obtained from Jim Ed Miller, 111 West Second Street, Pecos, Texas 79772, (915) 445–2037. TRD-9701551.

San Patricio Appraisal District, Board of Directors, will meet at 1146 East Market Street, Sinton, February 13, 1997 at 10:00 a.m. Information may be obtained from Kathryn Vermillion, P.O. Box 938, Sinton, Texas 78387, (512) 364–5402. TRD-9701533.

Meetings filed February 5, 1997

Bastrop Central Appraisal District, Appraisal Review Board, will meet at 1200 Cedar Street, Bastrop, February 11, 1997 at 8:30 a.m. Information may be obtained from Dana Ripley, 1200 Cedar Street, Bastrop, Texas 78602, (512) 303–3536. TRD-9701588.

Concho Valley Council of Governments, Executive Committee, will meet at 5014 Knickerbocker Road, San Angelo, February 12, 1997 at 7:00 p.m. Information may be obtained from Robert R. Weaver, P.O. Box 60050, San Angelo, Texas 76906, (915) 944–9666. TRD-9701590.

Dallas Central Appraisal District, Board of Directors, will meet at 2949 North Stemmons Freeway, Second Floor Community Room, Dallas, February 12, 1997 at 7:30 a.m. Information may be obtained from Rick Kuehler, 2949 North Stemmons Freeway, Dallas, Texas 75247, (214) 631–0520. TRD-9701603.

Erath County Appraisal District, Board of Directors, met at 1390 Harbin Drive, Stephenville, February 10, 1997 at 8:00 a.m. Information may be obtained from Angi Couch, 1390 Harbin Drive, Stephenville, Texas 76401, (817) 965–5434. TRD-9701581.

Grand Parkway Association, Board of Directors, will meet at 5757 Woodway, 140 East Wing, Houston, February 13, 1997 at 8:30 a.m. Information may be obtained from L. Diane Schenke, 5757 Woodway, 140 East Wing, Houston, Texas 77057, (713) 782–9330. TRD-9701591.

High Plains Underground Water Conservation District Number One, Board, will meet at 2930 Avenue Q, Board Room, Lubbock, February 11, 1997 at 10:00 a.m. Information may be obtained from A. Wayne Wyatt, 2930 Avenue Q, Lubbock, Texas 79405, (806) 762–0181. TRD-9701579.

IN ADDITION

The ***Texas Register*** is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings, changes in interest rate and applications to install remote service units, and consultant proposal requests and awards.

To aid agencies in communicating information quickly and effectively, other information of general interest to the public is published as space allows.

Texas Commission for the Blind

FFY 1997 Computer Access Technology Training Request for Proposals

Pat D. Westbrook, Executive Director of the Texas Commission for the Blind, has announced the availability of funds to contract for individualized computer hardware and software program training to consumers receiving services from the Commission and staff of the Commission who are blind or severely visually impaired. These proposals are requested to address unmet needs in specific applications and to provide this service in a more efficient and less costly manner. Additional coverage is sought for:

Specific Software–Windows95, MS Office Professional (includes: MSWord, Excel, MSAccess, MSMail), Internet (includes: Net Scape, MSExplorer), Arkenstone Open Book Unbound, Dragon Dictate, Type 'n Speak, Outspoken, Alva, and Jaws for '95.

All **geographic areas** of Texas with emphasis in Lubbock, Waco, Southeast Texas (including Harris county).

PRIMARY OBJECTIVE: The primary objective of the contracts is to enable consumers and staff who are blind or severely visually impaired to have access to work-place, task-specific, advanced training in the use of access hardware and software systems, and to the integration of software programs and hardware systems for employment, education and training applications. Trainers will be individuals familiar with computer technology, applications of the technology for consumers and staff who are blind and visually impaired, and methods of instructing consumers and staff who are blind and visually impaired. They will also have the ability to set software environments and create windows/macros (Form Fill) specific to an individual's needs on the job. Preference will be given to applicants with skills in computer interfacing and training. The following examples are provided as guides to training skills. They are not meant to be inclusive.

Computer interfacing: software customization to access mainframe or personal computer via adaptive software and devices; integration of adaptive software and hardware within a local area network.

Training: advanced skills with computer hardware/software; advanced skills with DOS and Windows 3.11 and Windows '95; advanced skills with specific software, e.g., WordPerfect, Lotus 1-2-3, PC-File+, Microsoft Office and other off-the-shelf software; advanced skills in accounting software.

Adaptive technology: large print programs, such as Vista, ZoomText, and LPDOS; speech screen review software, such as VocalEyes, Artic, and JAWS; and braille systems, such as Power Braille, ALVA, and Braille 'n Speak.

TARGETED POPULATION. Consumers served under these contracts are persons who are legally blind, totally blind, or severely visually impaired who have met the basic requirements for receiving services and have been referred by an authorized agency representative. Staff served under these contracts are persons referred by a regional supervisor or program supervisor.

WHO IS ELIGIBLE TO APPLY?. Organizations and individuals that provide computer technology training to persons who are legally or totally blind are eligible to apply for contracts.

APPLICATION PROCEDURES. ALL APPLICATIONS MUST BE POSTMARKED NO LATER THAN March 7, 1997. Submit to: MaryAnne Longenecker, Supervisor of Adaptive Services, Texas Commission for the Blind, 4800 N. Lamar, Austin, Texas 78756, a narrative no longer than five typed pages, which describes:

(1) individual or organization applying;

(2) proposed geographic coverage;

(3) quality and extent of services to be provided (list specific software and adaptive devices for visual loss);

(4) experience in providing adaptive technology interface and training to persons with visual loss;

(5) cost per person per hour for proposed training and method used to calculate cost;

(6) qualifications of key personnel,

(7) additional information about you or your organization and past achievements in serving the consumer who is visually impaired or blind;

(8) three letters of reference from individuals trained by the applicant (a requirement for both new applicants and existing consultants);

(9) a listing of agreements with other state agencies.

INQUIRIES: Interested parties are urged to contact the Texas Commission for the Blind with related questions prior to drafting proposals to facilitate the Request for Proposal process. Inquiries should be directed to MaryAnne Longenecker at (512) 467-6310.

METHOD OF PAYMENT. The service provider must submit a monthly statement containing a detailed listing of provided services and copies of training reports. Upon Commission approval of the submissions, payment shall be by state warrant.

REVIEW CRITERIA: **New applicants**: Reviewers will use the following criteria to evaluate proposals from new applicants:

(1) The proposal addresses the explicit purpose of the RFP.

(2) The applicant addresses expertise with the subject matter.

(3) The applicant provides evidence of their professional and organizational capacity to achieve the objectives in a timely manner.

(4) The applicant agrees to provide services to the consumer or staff at the trainee's work place.

(5) The applicant agrees to attend a one-day orientation in Austin.

(6) The applicant agrees to submit reports with required content within 30 days of completion of training.

In addition to the written criteria, the applicant will be requested by the Commission to demonstrate their knowledge of products via an assessment of a random sampling of adaptive and application software from the applicant's proposal.

Existing Consultants: Proposals from existing consultants will be reviewed based on:

(1) Review of feedback forms completed by consumers trained by consultants.

(2) Review of letters of reference from consumers trained by consultants.

(3) Review of quality and timeliness of reports sent to referring counselor and Adaptive Technology Unit within 30 days of training.

In addition to review of proposals, existing consultants will be requested by the Commission to demonstrate their expertise on new product areas included in their proposal.

ADDITIONAL FACTORS: Review of all proposals will include projected need for service by geographic area and/or training content. Reimbursement will be determined in relation to comparative rates for similar services and other factors.

Issued in Austin, Texas, on February 4, 1997.

TRD-9701541
Pat D. Westbrook
Executive Director
Texas Commission for the Blind
Filed: February 4, 1997

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Texas Department of Health

Notice of Major Consulting Services Contract Award

Pursuant to Texas Government Code 2254, Subchapter B, the Texas Department of Health will be entering into a major consulting services contract with an executive search firm to fill the Commissioner of Health position. This contract results from our invitation for proposal which was published in the October 29, 1996, issue of the *Texas Register* (21 TexReg 10783).

Description of Project: The search firm will: 1) identify suitable candidates for the position of Commissioner of Health; 2) work closely with the Board of Health (board) during the search process to determine the best candidates; 3) present a list of all qualified candidates to the board; 4) present monthly progress reports to the board; 5) present the top five candidates for the board to interview; 6) develop interview strategies and questions; and 7) conduct background checks on the top candidates presented to the board. In the event the candidate selected leaves or terminates within one year after employment, the search firm will provide other suitable candidates. In the event the board determines that none of the top five candidates meet the board's requirements, the firm will identify additional candidates based upon the board's further direction. The firm will maintain and retain supporting fiscal documents adequate to ensure that claims comply with the terms of the contract.

Name and Business Address of Private Consultant: Lehman McLeskey, 98 San Jacinto Boulevard, Suite 355, Austin, Texas 78701; mailing address - P.O. Box 2013-477, Austin, Texas 78768-2013.

Total Value: The total value of the contract is $42,500.

Dates of Contract: The contract period will begin upon signature of the contract by both parties, which is estimated to be no later than February 1, and will end upon completion of the services outlined in the contract.

Dates Reports are Due to Agency: Specific items are due to the agency as follows: (1) a preliminary search firm report due March 21, 1997; (2) a list of all candidates, recommended finalists, and an interim report due April 22, 1997; and (3) a final report from the search firm due May 1, 1997.

Issued in Austin, Texas, on January 30, 1997.

TRD-9701608
Susan K. Steeg
General Counsel
Texas Department of Health
Filed: February 5, 1997

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Notice of Request for Pricing

The Texas Department of Health (TDH), acting under contract with the Texas Health Care Information Council (THCIC), seeks a vendor to collect data on hospital discharges and other health services using administrative records (national uniform billing data element specifications as developed by the National Uniform Billing Committee through the UB-92 form or as specified in the Health Care Financing Administration form 1450 format) from all hospitals operating in the State of Texas with the exception of federally-

owned hospitals and those exempted as rural providers under the Health and Safety Code, ˘108.002, and deliver the data to the Texas Department of Health (TDH) under contract with the Texas Health Care Information Council (THCIC). Please note that the use of the acronym "TDH" throughout this document represents TDH acting as a data collection agent for the THCIC.

Data collection covering this function will be regulated by THCIC rule, Title 25, Texas Administrative Code, Part XVI, Chapter 1301. See publication of proposed rule in February 11, 1997, issue of the *Texas Register*. Final adoption of the rule is expected in March 1997. TDH reserves the right to change the description of services based on the adopted rule. Test submission of data by hospitals will begin 90 days after the date of final adoption of the rule. Collection of data is scheduled to begin with discharges occurring on or after July 1, 1997.

The proposed timeline for the request for pricing and the resulting contract is as follows:

The deadline for receipt of written questions regarding the request for pricing is 3:00 p.m. Central Standard Time, February 19, 1997.

The pre-response conference date is February 21, 1997 in Austin, Texas.

The deadline for receipt of responses is 5:00 p.m. Central Standard Time, March 13, 1997.

The tentative contract award date is March 25, 1997.

The scheduled date for acceptance of data submissions from hospitals for test purposes is July 1, 1997.

The proposed date that the system will be fully operational to accept data submissions from hospitals for actual collection is August 31, 1997

The expiration date of contact is August 31, 2000.

A contract award will be based on the financial stability of the vendor, the experience of the vendor in providing similar data collection services, the ability of the vendor to meet the technical specifications of the THCIC, the costs to the state of Texas and the vendor's ability to meet the proposed time line. All other considerations being equal, preference will be given to a vendor whose principal place of business is within the State or who will manage the contract and deliver the services from an office within the State. Historically Underutilized Business are encouraged to apply.

A pre-response conference will be held on Friday, February 21, 1997, from 2:00 p.m. to 3:30 p.m. Central Standard Time at the Brown-Heatly Building - Room 6302, 4900 North Lamar, Austin, Texas. Attendance is not mandatory.

TDH reserves the right to accept or reject any or all responses submitted. The information contained in this notice of request for pricing is intended to serve only a general description of the services desired. Additional terms and conditions related to this request will be provided in the response preparation instructions. TDH intends to use responses to this notice as a basis for selection of a vendor for further negotiation of a contract. Issuance of this notice of request for pricing creates no obligation to award a contract or to pay any costs incurred in the preparation of a response. Direct or indirect costs incurred in responding to the request for pricing are the sole responsibility of the respondents.

The complete request for pricing will be available on February 11, 1997. Organizations not currently classified as a Qualified Information Services Vendor must request copies of the request for pricing in writing under the Open Records Act. Copies of the request for pricing may be obtained by contacting: Mr. Randall D. Deavers, Texas Department of Health, Materials Acquisition and Management Division, 1100 West 49th Street, Austin, Texas 78756-3199, Phone: (512) 458-7744, Fax: (512) 458-7244.

Issued in Austin, Texas, on February 5, 1997.

TRD-9701598
Susan K. Steeg
General Counsel
Texas Department of Health
Filed: February 5, 1997

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Texas Health and Human Services Commission

Request for Information

The Texas Health and Human Services Commission (HHSC), Office of Operations-Medicaid Provider Sanctions Division, is requesting information regarding the availability of automated data systems which can be used to detect fraud, abuse, and waste in Texas Medicaid programs; and, the availability of a system (data warehouse) that would enable the State to bring together the various individual Medicaid data storage and data retrieval systems currently in operation. Each area of interest is described separately as follows:

I. Medicaid Fraud and Abuse Detection System for Texas (MFADS) Application

HHSC is interested in receiving information from prospective vendors regarding a MFADS application, accessible through a network that allows authorized users to view, access, and report data as needed, and is operational as either a stand-alone system, or as an attachment to a data warehouse system. The application must have the demonstrable capacity to perform the following tasks and functions:

A. Analyze and identify suspicious or aberrant patterns of practice for providers in both a fee-for-service claim environment and a managed care encounter data environment;

B. Analyze and identify patterns of suspicious recipient behavior in both a fee-for-service and a managed care environment;

C. Provide analytical on-line tools to identify to the lowest possible level of detail, the data elements/components of the various analytical outcomes;

D. Provide various reporting mechanisms and techniques that allow the user to control the output report;

E. Generate statistically valid random data samples for purposes of investigation, identification of overpayments payments, and projection of overpayments into a payment universe for potential collection;

F. Provide a standardized reporting capability on providers or recipients identified by the system;

G. Provide ad hoc reporting capability to support the development of charts, graphs, tables, or other documentation for use in case development, investigation, and prosecution of suspected cases of fraud or abuse identified by the system;

H. Track, manage, or otherwise control the assignment of, access to, or investigation of cases identified by the system;

I. Store, download, and retain data generated by this system;

J. Provides adequate data security and protection of recipient rights of confidentiality.

II. Data Warehouse/Central Data Library

HHSC, in conjunction with the Texas Department of Health (TDH), the Texas Department of Human Services (TDHS), and the Texas Department of Mental Health and Mental Retardation (TDMHMR), is requesting information regarding the availability of a system to accumulate, store, maintain, and provide functional access to data from various sources which support the state's Medicaid programs. Potential vendors should take into consideration the fact that HHSC estimates that the volume of data to be maintained is one (1) terabyte and is expected to increase over time. Potential vendors should accordingly provide information regarding the following matters:

A. Data extraction tools/methods from a variety of data sources

B. Data editing/cleansing and loading tools/processes/services

C. Database development/maintenance tools

D. Data structures, modeling, design, organization, data integrity and quality

E. Tools/applications to plan, design, and evaluate Medicaid programs in a mixed environment of managed care and fee-for-service coverage

F. Ad-hoc reporting capabilities to include the incorporation within Web browsers

G. End User access tools

H. Analytical tools/processes to include forecasting and trend analysis

I. Data mining tools and techniques

J. Data visualization/presentation tools and techniques

K. Medicaid specific applications to include Surveillance and Utilization Review Subsystems (SURS), Quality monitoring, Management and Administrative Reporting Subsystem (MARS), Third Party Recovery (TPR) billing/recovery etc.

L. Data Replication or data migration tools and processes

M. META data development, maintenance, management and use

N. Data Security and client confidentiality safeguards

O. Data and System back-up/restore processes and scheduling

P. System redundancy needs

Q. Application development to include recommendations on whether it should be included in the data warehouse contract or a separate contract

R. Hardware requirements to include ownership, operation and maintenance recommendations

S. Project management/implementation process recommendations

T. Data warehouse location, networks, Wide Area Network (WAN), Local Area Network (LAN), Intranet, and Internet interfaces

U. Performance factors to include application scheduling, processing and response times

V. Other data warehouse considerations to include planning, management, implementation and on-going operation and possible staffing requirements for each

W. Operational Models (e.g. procure as a service, procure as a turnkey operation, procure develop and implement as an in-house application.

Vendors responding to either the MFADS or Data Warehouse/Central Data Library portion of this RFI are requested to: provide literature, specification sheets, handouts, other pertinent information, and must be prepared to provide specific information relative to the methods of achieving each of the functions outlined under each category.

Potential vendors are advised that this RFI is issued solely for the purpose of obtaining information for consideration by HHSC in analyzing appropriate and suitable technologies and in preparing specifications for a potential future request for proposal(s). HHSC shall have the sole discretion to reject or disregard any information submitted in response to this RFI, it is determined to be in the State's best interest.

This RFI does not constitute a solicitation of proposals, a commitment to conduct a procurement, or an offer of a contract or prospective contract. HHSC shall not be liable for any cost incurred by any potential vendor in the preparation and submission of information in response to this RFI.

Potential vendors must identify either the MFADS application or the data warehouse/central data library system, or both, when providing information in response to this RFI. Information provided in response to this RFI may be in the form of literature, specification sheets, handouts, brochures, videos, and other information, prepared either for general distribution or specifically for this RFI, that describes in detail the following:

* Examples of similar services provided to other accounts with similar size and configuration;

* Basic process and functional features of the system or application;

* Platform(s) on which the system or application is operational;

* User interfaces;

* Language(s) in which the system or application is written;

* LAN, WAN, mainframe support functionality;

* The system's or application's incorporation of or reliance on other tools or applications, if any, and the nature of any such incorporation or reliance;

* Customization of the system or application, such as:

a) whether the system or application can be customized and, if so, how the customization can be achieved;

b) Degree of complexity in customizing the system or application with respect to operating platforms, functionality, database structures, etc.;

* Historical data, such as:

a) Length of time the system or application has been in production;

b) Number and type of customers previously or currently served; and

c) Previous customization of the system or application, if any;

* Scalability and evolution potential;

* Vendor capability to provide ongoing technical support;

* Training programs for administrative, technical, and user staff;

* Associated critical success factors, such as:

a) Project

b) Application

c) Platform

Please include list prices in your response(s).

In your response to this RFI, please specify how and/or within what parameters each of the products can meet the requirements outlined above.

HHSC may wish to determine that the system(s) is/are currently operating successfully in comparable sites within the mainland United States. A list identifying the names of at least three sites along with the name of a contact person and a current telephone number at each site for each product presented is requested.

Please submit your responses for consideration by 5:00 p.m., CST, on the 30th day after publication in Texas Register.

Offerors must submit six copies of their response, either by United States mail, or other method that requires a mailing address to Diane C. Davis, Medicaid Provider Sanctions Division, Texas Health and Human Services Commission, P.O. Box 13247, Austin, Texas 78711-3247; or by delivery to: Diane C. Davis, Medicaid Provider Sanctions Division, Texas Health and Human Services Commission, Brown-Heatly Building, 4900 North Lamar Boulevard, Suite 4100, Austin, Texas 78751.

Telephone inquiries are discouraged. However, for specific questions or concerns relating to this RFI, please contact Diane C. Davis at AC (512) 424-6522.

Following a review period of product literature and responses provided to the questions identified previously, and it is determined that it is in the best interest of the agency, HHSC staff may contact the vendor to request a product demonstration.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701570
Marina Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: February 4, 1997

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Texas Lottery Commission

Invitation for Bids for Security System

The Texas Lottery Commission is soliciting bids for a new Security System for the Texas Lottery Commission headquarters located in Austin, Texas as provided in the Invitation for Bid.

Objectives.

The Texas Lottery requires the vendor to provide installation of a new Security System at the Texas Lottery Commission's new headquarters. Monthly monitoring and maintenance will be required. Ability to complete project by April 18, 1997, will be a factor in award. Vendors will be required to visit the site to compile their bid.

Schedule.

Event-IFB Issued; Date-February 11, 1997; Bid Due Date-February 18, 1997, 11:00 a.m. CT

Primary term. Prices quoted must be in effect for the primary term of this contract which is the date of execution through August 31, 1997. At its sole option, the Texas Lottery Commission may extend this contract for four one-year periods following the primary term (August 31, 1997).

For a copy of the complete Invitation for Bids please contact:

Joanne Severn

Purchasing Supervisor, Texas Lottery Commission, (512) 323-3662

Issued in Austin, Texas, on February 5, 1997.

TRD-9701606
Ridgely C. Bennett
Commission Attorney
Texas Lottery Commission
Filed: February 5, 1997

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Texas Natural Resource Conservation Commission

Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Natural Resource Conservation Commission (TNRCC) Staff is providing an opportunity for written public comment on the listed Default Order. The TNRCC Staff proposes Default Orders when the Staff has sent an Executive Director's Preliminary Report (EDPR) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance, and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPR. Similar to the procedure followed with respect to Agreed Orders entered into by the Executive Director of the TNRCC pursuant to the Act, this notice of the proposed orders and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is March 12, 1997. The TNRCC will consider any written comments received and the TNRCC may withhold approval of a Default Order if a comment indicates the proposed Default Order is inappropriate, improper, inadequate, or inconsistent with the requirements of the Act. Additional notice will not be made if changes to a Default Order are made in response to written comments.

A copy of the proposed Default Order is available for public inspection at both the TNRCC's Central Office, located at 12100 Park 35 Circle, Building A, Third Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable Regional Office listed as follows. Written comments about the Default Order should be sent to the Staff Attorney designated for the Default Order at the TNRCC's Central Office at P.O. Box 13087 Austin, Texas 78711-3087 and must be received by 5:00 p.m. on March 12, 1997. Written comments may also be sent by facsimile machine to the Staff Attorney at (512) 239-3434. The TNRCC Staff Attorneys are available to discuss the Default Order and/or the comment procedure at the listed phone numbers; however, comments on the Default Order should be submitted to the TNRCC in writing.

(1) COMPANY: Robert Lawrence, doing business as Gary James Paint and Body; DOCKET NUMBER: 96-0671-AIR-E; ACCOUNT NUMBER: DB-3885-V; LOCATION: Dallas, Dallas County, Texas; TYPE OF FACILITY: vehicle refinishing operation; RULE VIOLATED: 30 TAC §115.422(1)(A) and the Act, §382.085(b) by failing to install and operate a system in which the painting equipment, including the sprayguns, nozzles, bowls, and other equipment, was totally enclosed during the washing, rinsing, and draining procedures, thus allowing the release of VOCs into the atmosphere; 30 TAC §115.422(2) and the Act, §382.085(b) by failing to utilize coating application equipment (i.e., paint guns) with a transfer efficiency of at least 65%; 30 TAC §115.426(a)(1)(A) and the Act, §382.016 by failing to maintain records documenting the VOC content, composition, solids content, solvent density; PENALTY: $500; STAFF ATTORNEY: Mary Risner, MC-175, 239-6224; REGIONAL OFFICE: 6421 Camp Bowie Boulevard, Suite 312; Fort Worth, Texas 76116.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701586
Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission
Filed: February 5, 1997

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Notice of Opportunity to Comment on Settlement Agreements of Administrative Enforcement Actions

The Texas Natural Resource Conservation Commission (TNRCC) Staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) pursuant to the Health and Safety Code, the Texas Clean Air Act (the Act), Chapter 382, §382.096. The Act, §382.096 requires that the TNRCC may not approve these AOs unless the public has been provided an opportunity to submit written comments. Section 382.096 requires that notice of the proposed orders and of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is March 12, 1997. Section 382.096 also requires that the TNRCC promptly consider any written comments received and that the TNRCC may withhold approval of an AO if a comment indicates the proposed AO is inappropriate, improper, inadequate, or inconsistent with the requirements of the Act. Additional notice is not required if changes to an AO are made in response to written comments.

A copy of each of the proposed AOs is available for public inspection at both the TNRCC's Central Office, located at 12100 Park 35 Circle, Building A, Third Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable Regional Office listed as follows. Written comments about these AOs should be sent to the staff attorney designated for each AO at the TNRCC's Central Office at P.O. Box 13087 Austin, Texas 78711-3087 and must be received by 5:00 p.m. on March 12, 1997. Written comments may also be sent by facsimile machine to the staff attorney at (512) 239-3434. The TNRCC staff attorneys are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §382.096 provides that comments on the AOs should be submitted to the TNRCC in writing.

(1) COMPANY: Fina Oil and Chemical Company; DOCKET NUMBER: 97-0023-AIR-E; ACCOUNT NUMBER: JE-0005-H; LOCATION: Port Arthur, Jefferson County; TYPE OF FACILITY: petroleum refinery plant; RULE VIOLATED: 30 TAC §§101.20(1)-(3), 115.112(a)(1), 115.322(a)(4) and (5), 115.324(a)(2)(c), 116.115, the Act, §382.085(b), and 40 Code of Federal Regulations, §§60.592(a), 60.482-7(a), 61.242-1(d), 60.112(a)(2), 60.693.1(c), and 60.7(c)(2)-(3) by failure to equip each open-ended valve or line with a cap, plug, blind flange, or second valve; failure to monitor quarterly the emissions from all pipelines in liquid service; failure to mark each piece of equipment in benzene service in such a manner that it can be distinguished easily from other pieces or equipment; failure to clearly mark pipeline valves and pressure relief valves in gaseous Volatile Organic Compound (VOC) service in such a manner that the valves were readily obvious to monitoring personnel; failure to attach to a leaking component, from which a leak has been detected, a weatherproof and readily visible tag with an identification number, and the date the leak was detected; stored a VOC in a stationary tank, reservoir, or other container without the container being capable of maintaining working pressure sufficient at times to prevent any vapor gas loss to the atmosphere or being equipped with at least a control device; failure to direct all waste gas and acid gas from a point source to a flare, an incinerator, or recovery system, failure to route truck loading emissions from the Sulfur Recovery Units to the tail gas incinerator, and failure to restrict emissions from the Sulfur Recovery Units sulphur pits to "Emergency Only"; failure to monitor the VOC associated with the FPM Cooling Tower every month with an approved air stripping system or equivalent; failure to limit VOC emissions to 6.6 tons per year; failure to submit notification, through a report of the construction and operation of four closed drain systems; and failure to submit an excess emissions report including specific identification of each period of excess emissions that occurred during malfunctions of the affected facility and the date and time identifying each period which the continuous emissions monitoring system was not operating; PENALTY: $286,500; STAFF ATTORNEY: Lisa Newcombe, MC-175, (512) 239-2269; REGIONAL OFFICE: 3870 Eastes Freeway, Suite 110, Beaumont, Texas 77703-1830.

(2) COMPANY: K and K Plating; DOCKET NUMBER: 96-1253-AIR-E; ACCOUNT NUMBER: KB-0148-A; LOCATION: 212 South Main Street, Kemp, Kaufman County, Texas; TYPE OF FACILITY: chromium plating shop; RULE VIOLATED: 30 TAC §116.110 and the Act, §382.0518(a) and §382.085(b) by constructing a chromium plating shop without obtaining a permit or qualifying for a standard exemption.; PENALTY: $0; STAFF ATTORNEY: Cecily Small, MC-175, (512) 239-2940; REGIONAL OFFICE: 6421 Camp Bowie Boulevard, Suite 312, Fort Worth, Texas 76116.

(3) COMPANY: One Stop Food Store, Inc.; DOCKET NUMBER: 96-0777-PST-E; ACCOUNT NUMBER: E11524; LOCATION: 1902 North Central Expressway, McKinney, Collin County, Texas; TYPE OF FACILITY: gasoline dispensing facilities; RULE VIOLATED: 30 TAC §115.241 and §115.249 and the Act, §382.003(12) by failing to install an approved Stage II vapor recovery system, by the scheduled installation date, which is certified to reduce the emissions of VOCs to the atmosphere by at least 95%; PENALTY: $10,000; STAFF ATTORNEY: Walter Ehresman, MC-175, (512) 239-0573; REGIONAL OFFICE: 6421 Camp Bowie Boulevard, Suite 312, Fort Worth, Texas 76116.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701587
Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission
Filed: February 5, 1997

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Public Notice

Texas Natural Resource Conservation Commission (TNRCC) announces the extension of the public comment period for the second draft of the Texas Risk Reduction Program Conceptual Document **to February 24, 1997**.

The conceptual document may be obtained in electronic format or in a hard copy format. For electronic format, the file may be accessed through the World Wide Web at URL http://www.tnrcc.state.tx.us/waste/riskred2.htm. Copies of the document are available in the Office of Policy and Regulatory Development, TNRCC, 4th floor, Building F, Room 4101, 12100 Park 35 Circle, Austin, Texas 78753. The phone number is (512) 239-4900. Due to limited quantities, TNRCC may restrict the number of copies sent out per request.

Comments may be mailed, faxed or hand-delivered to Clark Talkington, Waste Policy & Regulations Division, Texas Natural Resource Conservation Commission, MC-203, P.O. Box 13087, Austin, Texas, 78711-3087; fax numbers are (512) 239-5687 or (512) 239-6385. Hand-carried letters and over-night mail should be delivered to the physical address noted previously for the Office of Policy and Regulatory Development. All faxes should be followed with originals in the mail.

The commission will not accept comments that are submitted as confidential or privileged information. Unless TNRCC receives the original in the mail, a fax cover sheet containing a confidentiality clause should include a statement that the enclosed contents are not confidential or privileged, or the confidentiality clause should be stricken from the cover sheet.

For further information regarding this notice, please contact Clark Talkington at (512) 239-6731.

Issued in Austin, Texas, on February 3, 1997.

TRD-9701599
Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission
Filed: February 5, 1997

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Requests for Applications- Notification of Availability of Grants to Local Governments and Private Entities Supporting Used Oil Collection Projects

The Texas Natural Resource Conservation Commission (TNRCC) invites applications from local governments and private entities for funding to enable establishment and implementation of programs or activities to facilitate the collection, handling and reuse or recycling of used automotive oil generated by vehicle owners/operators who change their own automotive oil.

The purpose of this grant program is to further the accomplishment of the waste reduction and recycling goals as amended by Senate Bill 1683, 74th Texas Legislature (1995) and the TNRCC. Specifically, this grant program is designed to develop and implement a household do-it-yourselfer (DIYer) used oil program that encourages the collection, reuse, and recycling of household DIYer used oil.

The maximum amount individual applicants may request under this RFA is $50,000. Any amounts above $50,000 will be considered on a case by case basis. No award to a single applicant shall be less than $3,000. Matching funds are not required. The TNRCC will make multiple grant awards under this RFA. Grant funding will vary among selected applicants and will be awarded on a first come, first serve basis, terminating no later than July 31, 1997 (subject to change). Grants will be awarded as they are received and approved up to 5:00 p.m. Friday, July 18, 1997, unless funds are depleted before this date.

Eligible applicants are local governments and private entities as defined in 30 Texas Administrative Code (TAC), Chapter 330.973. To be eligible to receive a grant under this Request for Application (RFA), prospective recipients must not be in arrears in the payment of any municipal solid waste or hazardous waste fee or franchise taxes owed the State of Texas. All funding awarded under this RFA shall be from the Used Oil Recycling Fund, established under Texas Health and Safety Code, Chapter 371.061. Individuals desiring further information concerning this RFA and to request copies may telefax, write or call the TNRCC requesting Grant Application Packet Number. 97A-OIL-2 from: Tamie Magnuson, Grants Assistant, Texas Natural Resource Conservation Commission, Municipal Solid Waste Division, P.O. Box 13087/MC 125, Austin, Texas 78711-3087, (fax) (512) 239-3223, or (phone) (512) 239-6692.

Issued in Austin, Texas, on February 5, 1997.

TRD-9701600
Kevin McCalla
Director, Legal Division
Texas Natural Resource Conservation Commission
Filed: February 5, 1997

♦ ♦ ♦

Public Utility Commission of Texas

Notice of Application Pursuant to Public Utility Commission Substantive Rule 23.94

Notice is given to the public of the filing with the Public Utility Commission of Texas an application on January 29, 1997, pursuant to Public Utility Commission Substantive Rule 23.94 for approval of a rate change.

Tariff Title and Number: Application of Muenster Telephone Corporation of Texas (Muenster) for Approval of a Rate Change Pursuant to Public Utility Commission Substantive Rule 23.94. Tariff Control Number 16983.

The Application: Muenster proposes increasing rates for the following services throughout its service territory: monthly local residential and business exchange rates, the service ordering charge, central office access charge, trip charge and line access connection charge.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas, by mail at P.O. Box 13326, Austin, Texas, 78711-3326, or call the Public Utility Commission Consumer Affairs Section at (512) 936-7120. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

Issued in Austin, Texas, on February 4, 1997.

TRD-9701569
Paula Mueller
Secretary of the Commission

Public Utility Commission of Texas
Filed: February 4, 1997

♦ ♦ ♦

Notice of Workshop on Public Utility Commission Substantive Rule 23.97

The Public Utility Commission of Texas (PUC) plans to hold a workshop on February 21, 1997, to review the commission's Interconnection rule (PUC Substantive Rule §23.97) in light of the Federal Telecommunications Act of 1996 (FTA96) and discuss any amendments to the rule that may be appropriate. The workshop will be held from 1:00 p.m. until 4:00 p.m. in the PUC training room on the seventh floor of the Travis Building located at 1701 North Congress Avenue in Austin, Texas. Parties may, if they desire, bring any proposed amendment language to the workshop. The commission is tentatively scheduled to address any proposed changes in April, 1997.

Persons who plan to attend the workshop should register with Lucila Etheridge at (512) 936-7259. If there are any questions, contact Nelson Parish at (512) 936-7257 or Meena Thomas at (512) 936-7243.

Issued in Austin, Texas, on February 4, 1997.

TRD-9701552
Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas
Filed: February 4, 1997

♦ ♦ ♦

Texas Low-Level Radioactive Waste Disposal Authority

Correction of Errors

The Texas Low-Level Radioactive Waste Disposal submitted a Notice of Open Meeting on January 28, 1997. The notice appeared in the February 4, 1997, issue of the *Texas Register* (22 TexReg 1344).

An error was contained in the notice. The agenda summary began with the "Compensation Committee of the Board of Directors." The correct committee is the "Public Information Committee of the Board of Directors."

♦ ♦ ♦

State Securities Board

Correction of Errors

The State Securities Board proposed an amendment to 7 TAC §123.3. The rule appeared in the January 31, 1997, issue of the *Texas Register* (22 TexReg 1021).

On page 1022, §123.3(c)(1), line 11, the word "whether" should be in bold text.

♦ ♦ ♦

Southwest Texas State University

Consultant Proposal Request

This consultant proposal request is filed in compliance with the requirement under the Government Code, Chapter 2254, Subchapter B.

Southwest Texas State University in San Marcos solicits proposals for its major gifts campaign. This consulting service is continuation of a service previously performed by The Dini Partners, Houston, Texas.

The firm must have a proven track record assisting large state universities in Texas with similar campaigns.

The contractor must provide advice and guidance on research, cultivation, solicitation and stewardship for private gifts to the university.

Assistance with the recruitment and training of volunteer leadership, goal setting, campaign accounting procedures and overall assistance are also required.

Southwest Texas will give preferential consideration to firms who have previous experience working with Southwest Texas State University.

Contact: Gerald W. Hill, Vice President for University Advancement, Southwest Texas State University, San Marcos, Texas 78666-4612

Closing Date: 30 days from posting date. Contract will be awarded by the Board of Regents, Texas State University System.

Issued in San Marcos, Texas on January 29, 1997.

TRD-9701513
William A. Nance
Vice President
Southwest Texas State University
Filed: February 3, 1997

♦ ♦ ♦

Texas Water Development Board

Applications Received

Pursuant to the Texas Water Code, §6.195, the Texas Water Development Board provides notice of the following applications received by the Board:

Idlewood Water Control and Improvement District, P.O. Box 3056, Lufkin, Texas, 75903-6832, received October 1, 1996, application for financial assistance in the amount of $1,650,000 from the State Water Pollution Control Revolving Fund.

City of Quinlan, 104 East Main, Quinlan, Texas, 75474, received October 1, 1996, application for financial assistance in the amount of $845,000 from the State Water Pollution Control Revolving Fund.

City of Fate, 105 East Fate Main Place, Fate, Texas, 75132, received August 30, 1996, application for financial assistance in the amount of $1,000,000 from the State Water Pollution Control Revolving Fund.

City of Corsicana, 200 North 12th Street, Corsicana, Texas, 75110, received December 27, 1996, application for financial assistance in the amount of $10,075,000 from the State Water Pollution Control Revolving Fund.

South Plains Underground Water Conservation District, P.O. Box 986, Brownfield, Texas, 79316, received January 27, 1997, appli-

cation for financial assistance in the amount of $250,000 from the Agricultural Water Conservation Loan Program.

Bexar-Medina Atascosa Water Control and Improvement District Number 1, P.O. Box 170, Natalia, Texas, 78059, received January 14, 1997, application for financial assistance in an amount not to exceed $150,000 from the Research and Planning Fund.

Brazos River Authority-Erath County, 4400 Cobbs Drive, Waco, Texas, 76714-7555, received January 27, 1997, application for financial assistance in an amount not to exceed $100,000 from the Research and Planning Fund.

South Texas Development Council, P.O. Box 2187, Laredo, Texas, 78044-2187, received October 14, 1996, application for financial assistance in an amount not to exceed $100,000 from the Research and Planning Fund.

Additional information concerning this matter may be obtained from Craig D. Pedersen, Executive Administrator, P.O. Box 13231, Austin, Texas, 78711.

Issued in Austin, Texas, on February 5, 1997.

TRD-9701589
Craig D. Pedersen
Executive Administrator
Texas Water Development Board
Filed: February 5, 1997

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January - December 1997 Publication Schedule

The following is the January-December 1997 Publication Schedule for the *Texas Register*. Listed below are the deadline dates for these issues of the *Texas Register*. Because of printing schedules, material received after the deadline for an issue cannot be published until the next issue. No issues will be published on May 30, November 14, December 2, and December 30. An asterisk beside a publication date indicates that the deadlines are early due to state holidays.

FOR ISSUE PUBLISHED ON:	**DEADLINES FOR RULES BY 10 A.M.**	**DEADLINES FOR MISCELLANEOUS DOCUMENTS BY 10 A.M.**	**DEADLINES FOR OPEN MEETINGS BY 10 A.M.**
1 Friday, January 3	*****Monday, December 23	Monday, December 30	Monday, December 30
2 Tuesday, January 7	Monday, December 30	*****Tuesday, December 31	*****Tuesday, December 31
3 Friday, January 10	*****Tuesday, December 31	Monday, January 6	Monday, January 6
4 Tuesday, January 14	Monday, January 6	Wednesday, January 8	Wednesday, January 8
5 Friday, January 17	Wednesday, January 8	Monday, January 13	Monday, January 13
6 Tuesday, January 21	Monday, January 13	Wednesday, January 15	Wednesday, January 15
7 Friday, January 24	Wednesday, January 15	*****Friday, January 17	*****Friday, January 17
Tuesday, January 28	*1996 Annual Index*		
8 Friday, January 31	Wednesday, January 22	Monday, January 27	Monday, January 27
9 Tuesday, February 4	Monday, January 27	Wednesday, January 29	Wednesday, January 29
10 Friday, February 7	Wednesday, January 29	Monday, February 3	Monday, February 3
11 Tuesday, February 11	Monday, February 3	Wednesday, February 5	Wednesday, February 5
12 Friday, February 14	Wednesday, February 5	Monday, February 10	Monday, February 10
13 Tuesday, February 18	Monday, February 10	Wednesday, February 12	Wednesday, February 12
14 Friday, February 21	Wednesday, February 12	*****Friday, February 14	*****Friday, February 14
15 Tuesday, February 25	*****Friday, February 14	Wednesday, February 19	Wednesday, February 19

FOR ISSUE PUBLISHED ON:	DEADLINES FOR RULES BY 10 A.M.	DEADLINES FOR MISCELLANEOUS DOCUMENTS BY 10 A.M.	DEADLINES FOR OPEN MEETINGS BY 10 A.M.
16 Friday, February 28	Wednesday, February 19	Monday, February 24	Monday, February 24
17 Tuesday, March 4	Monday, February 24	Wednesday, February 26	Wednesday, February 26
18 Friday, March 7	Wednesday, February 26	Monday, March 3	Monday, March 3
19 Tuesday, March 11	Monday, March 3	Wednesday, March 5	Wednesday, March 5
20 Friday, March 14	Wednesday, March 5	Monday, March 10	Monday, March 10
21 Tuesday, March 18	Monday, March 10	Wednesday, March 12	Wednesday, March 12
22 Friday, March 21	Wednesday, March 12	Monday, March 17	Monday, March 17
23 Tuesday, March 25	Monday, March 17	Wednesday, March 19	Wednesday, March 19
24 Friday, March 28	Wednesday, March 19	Monday, March 24	Monday, March 24
25 Tuesday, April 1	Monday, March 24	Wednesday, March 26	Wednesday, March 26
26 Friday, April 4	Wednesday, March 26	Monday, March 31	Monday, March 31
Tuesday, April 8	*First Quarterly Index*		
27 Friday, April 11	Wednesday, April 2	Monday, April 7	Monday, April 7
28 Tuesday, April 15	Monday, April 7	Wednesday, April 9	Wednesday, April 9
29 Friday, April 18	Wednesday, April 9	Monday, April 14	Monday, April 14
30 Tuesday, April 22	Monday, April 14	Wednesday, April 16	Wednesday, April 16
31 Friday, April 25	Wednesday, April 16	Monday, April 21	Monday, April 21
32 Tuesday, April 29	Monday, April 21	Wednesday, April 23	Wednesday, April 23
33 Friday, May 2	Wednesday, April 23	Monday, April 28	Monday, April 28
34 Tuesday, May 6	Monday, April 28	Wednesday, April 30	Wednesday, April 30
35 Friday, May 9	Wednesday, April 30	Monday, May 5	Monday, May 5
36 Tuesday, May 13	Monday, May 5	Wednesday, May 7	Wednesday, May 7
37 Friday, May 16	Wednesday, May 7	Monday, May 12	Monday, May 12
38 Tuesday, May 20	Monday, May 12	Wednesday, May 14	Wednesday, May 14

FOR ISSUE PUBLISHED ON:	DEADLINES FOR RULES BY 10 A.M.	DEADLINES FOR MISCELLANEOUS DOCUMENTS BY 10 A.M.	DEADLINES FOR OPEN MEETINGS BY 10 A.M.
39 Friday, May 23	Wednesday, May 14	Monday, May 19	Monday, May 19
40 Tuesday, May 27	Monday, May 19	Wednesday, May 21	Wednesday, May 21
Friday, May 30	*No Issue Published*		
41 Tuesday, June 3	*Friday, May 23	Wednesday, May 28	Wednesday, May 28
42 Friday, June 6	Wednesday, May 28	Monday, June 2	Monday, June 2
43 Tuesday, June 10	Monday, June 2	Wednesday, June 4	Wednesday, June 4
44 Friday, June 13	Wednesday, June 4	Monday, June 9	Monday, June 9
45 Tuesday, June 17	Monday, June 9	Wednesday, June 11	Wednesday, June 11
46 Friday, June 20	Wednesday, June 11	Monday, June 16	Monday, June 16
47 Tuesday, June 24	Monday, June 16	Wednesday, June 18	Wednesday, June 18
48 Friday, June 27	Wednesday, June 18	Monday, June 23	Monday, June 23
49 Tuesday, July 1	Monday, June 23	Wednesday, June 25	Wednesday, June 25
50 Friday, July 4	Wednesday, June 25	Monday, June 30	Monday, June 30
51 Tuesday, July 8	Monday, June 30	Wednesday, July 2	Wednesday, July 2
Friday, July 11	*Second Quarterly Index*		
52 Tuesday, July 15	Monday, July 7	Wednesday, July 9	Wednesday, July 9
53 Friday, July 18	Wednesday, July 9	Monday, July 14	Monday, July 14
54 Tuesday, July 22	Monday, July 14	Wednesday, July 16	Wednesday, July 16
55 Friday, July 25	Wednesday, July 16	Monday, July 21	Monday, July 21
56 Tuesday, July 29	Monday, July 21	Wednesday, July 23	Wednesday, July 23
57 Friday, August 1	Wednesday, July 23	Monday, July 28	Monday, July 28
58 Tuesday, August 5	Monday, July 28	Wednesday, July 30	Wednesday, July 30
59 Friday, August 8	Wednesday, July 30	Monday, August 4	Monday, August 4
60 Tuesday, August 12	Monday, August 4	Wednesday, August 6	Wednesday, August 6

FOR ISSUE PUBLISHED ON:	DEADLINES FOR RULES BY 10 A.M.	DEADLINES FOR MISCELLANEOUS DOCUMENTS BY 10 A.M.	DEADLINES FOR OPEN MEETINGS BY 10 A.M.
61 Friday, August 15	Wednesday, August 6	Monday, August 11	Monday, August 11
62 Tuesday, August 19	Monday, August 11	Wednesday, August 13	Wednesday, August 13
63 Friday, August 22	Wednesday, August 13	Monday, August 18	Monday, August 18
64 Tuesday, August 26	Monday, August 18	Wednesday, August 20	Wednesday, August 20
65 Friday, August 29	Wednesday, August 20	Monday, August 25	Monday, August 25
66 Tuesday, September 2	Monday, August 25	Wednesday, August 27	Wednesday, August 27
67 Friday, September 5	Wednesday, August 27	*****Friday, August 29	*****Friday, August 29
68 Tuesday, September 9	*****Friday, August 29	Wednesday, September 3	Wednesday, September 3
69 Friday, September 12	Wednesday, September 3	Monday, September 8	Monday, September 8
70 Tuesday, September 16	Monday, September 8	Wednesday, September 10	Wednesday, September 10
71 Friday, September 19	Wednesday, September 10	Monday, September 15	Monday, September 15
72 Tuesday, September 23	Monday, September 15	Wednesday, September 17	Wednesday, September 17
73 Friday, September 26	Wednesday, September 17	Monday, September 22	Monday, September 22
74 Tuesday, September 30	Monday, September 22	Wednesday, September 24	Wednesday, September 24
75 Friday, October 3	Wednesday, September 24	Monday, September 29	Monday, September 29
Tuesday, October 7	*Third Quarterly Index*		
76 Friday, October 10	Wednesday, October 1	Monday, October 6	Monday, October 6
77 Tuesday, October 14	Monday, October 6	Wednesday, October 8	Wednesday, October 8
78 Friday, October 17	Wednesday, October 8	Monday, October 13	Monday, October 13
79 Tuesday, October 21	Monday, October 13	Wednesday, October 15	Wednesday, October 15
80 Friday, October 24	Wednesday, October 15	Monday, October 20	Monday, October 20
81 Tuesday, October 28	Monday, October 20	Wednesday, October 22	Wednesday, October 22
82 Friday, October 31	Wednesday, October 22	Monday, October 27	Monday, October 27
83 Tuesday, November 4	Monday, October 27	Wednesday, October 29	Wednesday, October 29

FOR ISSUE PUBLISHED ON:	DEADLINES FOR RULES BY 10 A.M.	DEADLINES FOR MISCELLANEOUS DOCUMENTS BY 10 A.M.	DEADLINES FOR OPEN MEETINGS BY 10 A.M.
84 Friday, November 7	Wednesday, October 29	Monday, November 3	Monday, November 3
85 Tuesday, November 11	Monday, November 3	Wednesday, November 5	Wednesday, November 5
Friday, November 14	*No Issue Published*		
86 Tuesday, November 18	Monday, November 10	Wednesday, November 12	Wednesday, November 12
87 Friday, November 21	Wednesday, November 12	Monday, November 17	Monday, November 17
88 Tuesday, November 25	Monday, November 17	Wednesday, November 19	Wednesday, November 19
89 Friday, November 28	Wednesday, November 19	Monday, November 24	Monday, November 24
Tuesday, December 2	*No Issue Published*		
90 Friday, December 5	Wednesday, November 26	Monday, December 1	Monday, December 1
91 Tuesday, December 9	Monday, December 1	Wednesday, December 3	Wednesday, December 3
92 Friday, December 12	Wednesday, December 3	Monday, December 8	Monday, December 8
93 Tuesday, December 16	Monday, December 8	Wednesday, December 10	Wednesday, December 10
94 Friday, December 19	Wednesday, December 10	Monday, December 15	Monday, December 15
95 Tuesday, December 23	Monday, December 15	Wednesday, December 17	Wednesday, December 17
96 Friday, December 26	Wednesday, December 17	Monday, December 22	Monday, December 22
Tuesday, December 30	*No Issue Published*		

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